If you have issues viewing or accessing this file contact us at NCJRS.gov.

COCAINE ABUSE AND THE FEDERAL RESPONSE

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

TUESDAY, JULY 16, 1985

Printed for the use of the
Select Committee on Narcotics Abuse and Control

SCNAC-99-1-2

103467

NCJRS
NOV 10 1986
ACQUISITIONS

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1986

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

CHARLES B. RANGEL, New York, *Chairman*

PETER W. RODINO, Jr., New Jersey
FORTNEY H. (PETE) STARK, California
JAMES H. SCHEUER, New York
CARDISS COLLINS, Illinois
DANIEL K. AKAKA, Hawaii
FRANK J. GUARINI, New Jersey
ROBERT T. MATSUI, California
DANTE B. FASCELL, Florida
WALTER E. FAUNTROY, District of Columbia
WILLIAM J. HUGHES, New Jersey
MEL LEVINE, California
SOLOMON P. ORTIZ, Texas
LAWRENCE J. SMITH, Florida
EDOLPHUS "ED" TOWNS, New York

BENJAMIN A. GILMAN, New York
LAWRENCE COUGHLIN, Pennsylvania
E. CLAY SHAW, Jr., Florida
MICHAEL G. OXLEY, Ohio
STAN PARRIS, Virginia
GENE CHAPPIE, California
DUNCAN HUNTER, California
JOSEPH J. DioGUARDI, New York
MICHAEL L. STRANG, Colorado
JOHN G. ROWLAND, Connecticut

COMMITTEE STAFF

JOHN T. CUSACK, *Chief of Staff*
ELLIOTT A. BROWN, *Minority Staff Director*

U.S. Department of Justice
National Institute of Justice

This document has been reproduced exactly as received from the person or organization originating it. Points of view or opinions stated in this document are those of the authors and do not necessarily represent the official position or policies of the National Institute of Justice.

Permission to reproduce this ~~copyrighted~~ material has been granted by
Public Domain
U.S. House of Representatives
to the National Criminal Justice Reference Service (NCJRS).

Further reproduction outside of the NCJRS system requires permission of the ~~copyright~~ owner.

CONTENTS

HEARING ON COCAINE ABUSE AND THE FEDERAL RESPONSE

TUESDAY, JULY 16, 1985

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, DC.

The select committee met, pursuant to call at 9 a.m., in room 2237, Rayburn House Office Building, Hon. Charles B. Rangel (chairman of select committee) presiding.

Present: Representatives James H. Scheuer, Frank J. Guarini, Walter E. Fauntroy, Dante B. Fascell, Mel Levine, Solomon P. Ortiz, Lawrence J. Smith, Benjamin A. Gilman, Lawrence Coughlin, E. Clay Shaw, Jr., Stan Parris, Gene Chappie, and John G. Rowland.

Staff present: John T. Cusack, chief of staff; Elliott A. Brown, minority staff director; Ed Jurith, staff counsel; George Gilbert, staff counsel: Marc Lippman, staff counsel; Jehru Brown, investigator; Ronald LeGrand, staff counsel; Khalil Munir, investigator; Michael J. Kelley, staff counsel; James W. Lawrence, minority professional staff; and Pat Remick, press officer.

Mr. RANGEL. The Select Committee on Narcotics will come to order this morning.

We intend to report to the American people the ever-increasing danger of the cocaine epidemic which is sweeping our Nation from the jungles of Peru, Bolivia, and Colombia. Our committee has been able to report that we expect close to 100 tons of this white poison to creep into these United States.

This report is substantiated by the U.S. State Department, as well as the U.N. Committee on Drug Abuse.

Charts would indicate that while the quality is up, the price is down. From 1979 to 1980, we had 192 deaths due to overdoses of cocaine. This number has sharply skyrocketed in 1983, and 1984, where we had 456 deaths.

It is estimated that we have some over 25 million Americans that are contaminated by cocaine at a rate of 5,000 a day. Unfortunately, this addiction, unlike addiction to heroin, has been covered with glamorous and acceptable and recreational types of connotations which allowed this to creep into the lives of our young and our old, professionals, our politicians, our blue collar workers, and indeed our Nation must constantly be on the alert.

It has been the intent of this committee, through the U.S. Congress, to let every drug producing country know, whether friend or foe, that we will not tolerate their indifference to U.N. agreements,

international agreements, bilateral agreements, and they should not expect a continuation of military, economic, technical, and other type of assistance, as long as they violate these treaties.

In addition to that, we recognize that we must build up our law enforcement to such an extent that those that tamper with the lives of our young know that they must pay a price for doing that, but the most important is that we must educate our youth, and we must do all that we can do to prevent the spread of this deadly disease.

This morning, we have three courageous witnesses that will be sharing their tragic experiences with us in the hope that it will deter others from making the same type of mistakes. Before I introduce these witnesses, I would like to recognize the gentleman from New York, the ranking Republican and a person that has been fighting against the spread of drug abuse for over two decades, Congressman Benjamin Gilman.

[The statement of Mr. Rangel appears on p. 61.]

Mr. GILMAN. Thank you, Mr. Chairman, and I want to associate myself with your remarks and commend you for bringing together this important hearing at a very appropriate time when our Nation is confronted once again with a drug crisis, and I want to welcome those who have taken the time to come here to testify before the select committee on this ever-growing problem.

And I want to thank the panel of former cocaine users for appearing and their willingness to be frank and candid about their problem. Their willingness to share their experiences with us will be instrumental in helping us to alert the general public of the tremendous amount of dangers involved in cocaine abuse. And while they paid the price for their experience, they can now help play a key role in preventing others from making a similar mistake.

We all recognize that in this room, that cocaine is the most rapidly growing drug abuse in this country, and a swift and effective response by our Federal Government is going to be essential if we are to overcome this growing menace.

Actions taken must reflect the realization that both the supply of and demand for cocaine must be reduced. Both Congress and the administration have taken steps to reduce the supply of cocaine, but despite all of our efforts, greater supplies, resulting in lower prices, will be available in the United States during the current year than ever before. It is equally important to note that recent visits to the Select Committee on Narcotics Abuse and Control by representatives of the parliaments of Spain and the United Kingdom revealed great concern over cocaine abusers in their nations and other nations in Western Europe.

All of the cocaine affecting the United States originates in South America, and is produced by the coco leaf grown primarily in Bolivia and Peru. Just last Wednesday, the House adopted an amendment to the fiscal year 1986 foreign assistance authorization providing for the cutoff of economic and military assistance to these nations if they fail to develop and implement plans for the elimination of illegal coco production. We have high hopes that this legislation, coupled with bold political leadership in both Bolivia and Peru, will help intensify the urgency to curtail the illicit production of cocaine in that part of the world.

Until that occurs, however, we must face a cocaine abuse problem in this Nation that respects neither age, sex, race, nor economic status. There are currently an estimated 25 million users of cocaine in the United States, and an estimated 5,000 people try cocaine for the first time each day. Studies reveal that last year 16 percent of high school seniors reported trying cocaine—almost double the amount who had tried the drug in 1975. Cocaine has not only invaded our schools, but our places of work and even our corporate board rooms. The impact of lost productivity is difficult to determine, but there can be no doubt that it is significant. Most alarmingly, cocaine related deaths and emergency room visits increased by 300 percent from 1978 to 1983.

Through the testimony that we receive today, we hope to better understand what drives people to use this powerfully addictive drug and what research has revealed about the effects of cocaine use. In addition, we hope to learn about treatment methods that have proven to be effective for those seeking help, and we will examine what the Federal Government is doing to address this national health epidemic.

There has been, and continues to be, a perception that cocaine use can be a harmless, recreational activity. That perception must be destroyed, and I am confident that the testimony that we receive today will shatter that myth.

Mr. RANGEL. Thank you, Mr. Gilman.

The committee has been joined by Stan Parris of Virginia, who has coordinated an effort to improve the drug enforcement effort in the District of Columbia, and Mel Levine, and Larry Coughlin, one of the senior members of this committee from Pennsylvania, and Gene Chappie, who understand the problem of drug production abroad and suffers with drug production of marijuana in his own hometown in California, and of course, Clay Shaw whose community has been hit pretty hard in Florida, that constantly is reminding the Congress that we must use more of our military. And we have been successful in this session of Congress in getting involved.

The first panel will be people who have had tragic experiences and who have the courage to come before us today to share their experiences so other young people won't have to go through their experiences. After that, we will have some experts in this area, Dr. Ronald Dougherty of the Benjamin Rush Psychiatric Center in Syracuse who pioneered efforts in cocaine treatment, Richard Hamilton.

Later on this morning, we will hear from the administration, from James Mason, Acting Assistant Administrator for Health and Human Services, and he will be accompanied by Dr. Ian McDonald, and Dr. Snyder. Yes?

Mr. PARRIS. Mr. Chairman, I have a brief statement, but I would like unanimous consent to insert it in the record.

Mr. RANGEL. Without objection.

[The statement of Mr. Parris appears on p. 179.]

Mr. RANGEL. The first panel, we will call Stacy Keach, a well-known television star who has recently been released from jail in England for carrying cocaine. He served 6 months, and he comes before us this morning to make his first public statement in terms of this tragic event.

I want to thank Mr. Keach for his courage, because in the sensitive profession which he has chosen, it takes a lot of guts to come forward.

We also have Carl Eller, former NFL star and NFL drug consultant, 16 years, served on the Minnesota Vikings. And we are concerned that those starting in the athletic area not suffer the pains; and Mrs. Bernice Carrington is with us.

Ms. Carrington is local, and she has suffered a great deal, and it takes a lot of strength and we deeply appreciate Ms. Carrington for you to expose yourself to this type of publicity, but I think all of us are praying that the contribution that we make would help, no matter what side of the mikes we are on.

Mr. Keach.

TESTIMONY OF STACY KEACH, ACTOR

Mr. KEACH. Thank you.

Mr. Chairman, distinguished members of the committee, ladies and gentlemen, I would first like to thank Mr. Charles Rangel and Mr. Edward Jurith for inviting me here today to allow me to share my views with all of you concerning drug abuse, and specifically cocaine abuse.

Hopefully, my own personal experience with this deceiving drug will offer some positive insight, not only to this committee, but also to others interested in helping to combat this terrible epidemic spreading across our Nation.

The 1960's marked the advent of a cultural revolution in America, and unfortunately, for many young Americans, drugs became a kind of symbolic manifestation of freedom. What began as a seemingly harmless experiment in mind expansion, deeper self-awareness, collective joy and celebration has been transformed by time and experience into one of the most dangerously destructive forces in our society.

Many young people in America smoked marijuana and dabbled in hallucinogens in the 1960's and the 1970's, and then about the midseventies cocaine began to emerge as the drug of fashion among the elite in high society. Today, it has spread into virtually every level of our social and professional structure. It permeates Wall Street, the worlds of business, law and medicine, the entertainment industry, politics and sports, and has found its way into our schools.

In spite of our increasing efforts to stop it from coming across our borders, it continues to persist. It continues to be more readily available and in alarmingly greater quantities. Cocaine is a drug which initially entices the user as a pleasurable, recreational diversion, and because of its seductive nature, lures its victims into greater demands for constant companionship, finally forcing its prey into total submission, making of itself the exclusive and singular priority of a person's existence.

I know because I was a victim of this very phenomenon. My initial experience with cocaine was fairly typical for most first-time users. I felt euphoric, self-confident, alert and even creative. I was first introduced to the drug at a social gathering, but because I have always prided myself on the philosophy that I needed no stim-

ulant or crutch to assist me in any social or professional context, I simply regarded the event as a passing incident, amusing and harmless.

About a year later, I had my second encounter with the drug, and again the results were such so as to attract my curiosity to purchase my first gram. Little did I know at the time that I had already planted the seed for my own downfall. Within a few short months, cocaine became an integral part of my life, but I still foolishly and blindly refused to abandon the notion that I could take it or leave it. I thought that I was in control of the drug and not vice versa.

And this is one of the hallmarks of cocaine's destructive power. It always deludes the user into feeling that he or she is in complete control until it is too late. So distorted was my perspective that I was unwilling, unable to face the truth that the drug had begun to dominate my life. It wasn't until I was apprehended on April 3, 1984, in Heathrow Airport that the shock of recognition finally jolted me into realizing that the drug was controlling me, and not vice versa, and that I was helplessly at its mercy.

Unfortunately, it took this incident to change my life. For it was the trauma of this event which caused me to reestablish my priorities in their proper perspective. It was a costly revelation. But as I am alive and healthy, I can only thank God that I now have an opportunity to speak out to others in the hope that they will not have to travel down the same road as I did.

However, no one person can turn the tide that is sweeping our country. Cocaine abuse is a problem which demands all of our collective energies and human resources. For in my opinion, we are all responsible in one way or another for ensuring that our children and our grandchildren may be able to avoid the horrors of drug abuse.

We can no longer be as ostriches putting their heads into the sand, hoping the problem will go away. We can no longer deny the statistics. They compel us to recognize the prevalence of cocaine in our society. According to numerous surveys, and we have heard these figures quoted earlier, 20 to 45 million Americans have tried cocaine with some 5,000 new users introduced to the drug each day.

At this rate, over 1,800,000 people will experiment with the drug this year alone. The surveys further inform us that 25 percent of these people will become regular users. In my view, the most important way of dealing with this alarming and overwhelming reality is by continuing a two-pronged offensive. First, prevention through education, and second, rehabilitation through recognition.

In the first category, prevention through education, the primary objective is to make people aware, and most particularly young people, of the dangers of using cocaine. Happily, there are programs now in existence which provide us with model examples. For instance, the DARE Program, Drug Abuse Resistance Education, originated in southern California by the combined efforts of the Los Angeles Police Department, and the LAUSD Board of Education, where the police are the trained instructors, is proving to be enormously successful in teaching fifth and sixth graders to resist peer pressure and to say no to drugs.

The national PTA drug and alcohol abuse prevention project and the work of the First Lady have been exemplary in raising public awareness and deserve the highest possible praise. However, it is essential, I feel, that the Federal Government continues to work with the private sector in enlisting the talents of concerned citizens to help raise not only the necessary consciousness, but also the necessary funding to meet the growing demands for skilled personnel and proper facilities.

Cooperation between the public and the private sectors of our society is, I feel, the essential key to the success of these programs. Reaching people, a lot of people, with the message of how drugs can get you into trouble requires financial resources. And this is why I feel that the 99th Congress has no greater priority than the passage of H.R. 526. For only by the Federal Government's continued support may the States and their respective localities fulfill the hope that present and future generations of Americans may at least have a better chance to enjoy a future free from the abuse of drugs.

In the area of rehabilitation, we are blessed with some encouraging news. There are people under the influence of drugs who want help to get away from them. The service provided by the 800 cocaine hotline, led by Arnond Washington, is doing an amazing job of responding to this need. One report states that over 100,000 calls were received in just a 3-month period. The Ridgeview Institute in Smyrna, GA, is yet another example of the value of specialized centers of rehabilitation. Over 750 doctors in the medical profession have been helped to rid their lives of drug addicition.

The EAP, Employee Assistance Program, has been established by a growing number of businesses and corporations in an effort to deal more realistically with professionals, executives and laborers who use cocaine in order to keep going on the job. According to Dr. Mark Gold, workers who seek treatment and who respond favorably can have a good influence on coworkers and can actually encourage other users to seek help. The company's willingness to consider the former drug abuser an unwitting victim rather than a destructive influence, according to Dr. Gold, is proving to reap positive rewards in the workplace.

Similarly, the work of various treatment programs in professional sports is proving to have favorable results. But while all of these programs are important, they are still not enough. Hopefully, more programs of this nature, like the employee assistance programs will be adopted by more professional corporations to help their personnel get away from drugs. In the entertainment industry, for example, we are just beginning to witness new programs in each and every studio, and within each network. The entertainment industry Council for Drug Free Society, led by Brian Dayak, has been established as a response to the growing need for helping people who want to get help.

But what about the others who are victims of cocaine abuse? What about those individuals who refuse to seek help in spite of the warning signs, who refuse to seek help in spite of the opportunities provided for them to find help, and in spite of the growing awareness that cocaine is destructively dangerous? What about them? I can honestly say, I have no answer. And that is why I

know we must do everything in our power to prevent this condition from spreading further.

Because of this, I am strongly in favor of the work this committee is doing so that others will not have to learn their lesson the hard way, as I did; that others will not have to relinquish the precious gift of freedom, as I did. But finally, there is no greater imprisonment than that of being dependent on any chemical substance for one's existence.

By far, the worst form of incarceration is to be trapped within one's own powerlessness to help one's self. God willing, the message of this committee's work will not fall on deaf ears and will have a resounding echo in each corner of this Nation, that freedom from dependency on drugs is one of the most precious freedoms we have. And it must be a loving legacy for our children and their children as well. I thank you.

Mr. RANGEL. Thank you, Mr. Keach, for a very sensitive and well thought out statement.

We have been joined by Congressman Walter Fauntroy of the District of Columbia and with the permission of my members, we would like to take the testimony from the other two witnesses, and then with the witnesses' permission, we would like to inquire under the 5-minute rule.

Mr. RANGEL. The next witness is Carl Eller, as pointed out, twice an all star, all American in college and a star of the Minnesota Football Vikings.

TESTIMONY OF CARL ELLER, FORMER NFL PLAYER

Mr. ELLER. Thank you, Mr. Chairman, Congressmen and privileged guests. It is indeed a pleasure and an honor to be asked to speak to the Select Committee on Narcotics Abuse and Control.

I equate my feelings for this opportunity with those that Mahatma Ghandi, Sigmund Freud, Albert Einstein, and Gloria Steinem must have had. I relate to these people because I know how difficult it is to break new ground and change old habits, to give someone new concepts and to replace traditional thinking. I feel this is the journey I embark upon at this hearing.

The ideas I present to you today are my own. Forged from my own personal experiences and supported with much work and factual data collected over a period of years, my research has included surveys and questionnaires; personal interviews, plus information from one-on-one and group counseling sessions with athletes.

It is my desire to provide some answers to the question of why there are so many problems with athletes and with drug programs for athletes. It is from this stance that I approached Mr. Pete Rozelle, commissioner of the National Football League, with the idea of implementing a program to assist professional football athletes suffering from chemical abuse. I shared with him my own addiction to cocaine and other personal problems at this time.

Such a program required a major change in philosophy and attitude by the National Football League. The single most significant reason that drug programs in professional sports are unsuccessful is that they do not meet the needs of the athlete. At least one major league official, Mr. Peter Uberoth, baseball commissioner,

has admitted that their program is not working. Most of these programs are destined to fail from the start.

We must understand athletes at the professional level combine the skills of many professions to be successful. To some extent they have had to develop medical, psychological, sociological, theological, financial, and legal acuity. The major sports enterprise in America is divided into four professional leagues: baseball, basketball, football, hockey, consisting of 97 teams and employing some 2,755 athletes. By contrast, there are more law firms than there are players in major league sports, 2,800 law firms.

Many of the problems of pro atheletes begin in college. Can you imagine the dean of a medical school recruiting a brilliant young scholar and offering him or her a scholarship to attend their school to do extensive research writing elaborate papers for the department and bring numerous honors, then say to him or her, "I cannot give you a degree in medicine. You will have to get it in something else even though I know your desire is to become a doctor."

The athlete is the most discriminated person in our society today. Most people see the athlete as a highly paid professional. They do not think of him as the kid next door. We have over 30 million young people involved in sports, an experience that many Americans have had in their own lifetime. The reason people do not understand athletes or athletics is because there is no way to become educated in it and the only opportunities for education at the professional level is to be involved either as a player or coach.

I think we are sincerely lacking in the amount of expertise to develop the programs to help our young athletes to become citizens of tomorrow. The problem is not drug abuse. The problem is exploitation, not of the athletes, but of the community. An exploitation of the tremendous investment in raw material in the youth of our country who aspire to become athletes, who are inspired by athletes to become something more than they might have become otherwise.

In a "Comparison Study of Marijuana Use of Athletes to Nonathletes" developed by the U.S. Athletes Association, an organization which I founded to help young athletes develop leadership and to live balanced lives while still getting the benefits of sports participation, the following statement illustrates the commitment of a USAA member: that they will support the USAA, one, to develop leadership through athletics; two, to increase opportunity for sports participation; three, to promote a balanced life that includes a lifetime of sports and physical fitness; and four, to activate a chemically free lifestyle.

By contrast, the athletes are using about the same number as other students. The problem is the athletes do not seek help at the same levels the other students, and in a school where I ran this program, 51 percent of the student populations were athletes. The number of athletes that saw the counselor compared to a year previous to his initiating a program was 27 in 1984, 50 a year later, an increase of 3.

This was typical of the increases from 1 year ago where we had a total percentage increase of over 64 percent of the athletes who were using the programs. Our athletes do use drugs, and using

about the same rate as the other kids, and you would expect them to have the same amount of problems. Yet they do not seek help.

The problem being that they feel that they would jeopardize many of their opportunities for a career advancement in sports. Further, the athlete is expected to assume responsibility to be role models for other kids, when at the same time he wants to join and belong to their group without this punishment.

To thrust this responsibility upon him without the support, training or education to assist him in handling this responsibility is foolish. If we cannot prepare him then I think we will continue to see an increase in chemical abuse.

Not only have I developed a program for the young athletes, but for the professional athlete as well. Game plan II, a program used with the Minnesota Vikings this off-season does just that. Game plan II helps them prepare for that responsibility. Game plan II gives the professional athlete a chance to be normal. Game plan II is an exceptional program for exceptional people to give them a better than average chance against drug abuse.

I developed this program because I realized that when the athletes were not taking care of themselves, they were in fact bringing harm to themselves. Much of it in the form of alcohol and drugs. But game plan II does a lot more. It gives them a chance to live. Many athletes have died from a syndrome I call Hero-lism, the voluntary effort toward self-destruction.

They have died as much from that as they have from drugs. Bill Robizen, a basketball player, committed suicide from carbon monoxide poisoning, running his car in his garage. He couldn't handle it and there was no help. Larry Mickey, hockey player for the New York Rangers, committed suicide after not being able to make the adjustment to the world from pro life; the world of fantasy to the world of reality. Jim Tyrer, Kansas City Chief football player, committed suicide because the glory of the game did not follow him off the field. Big Daddy Lipscomb died from an overdose of heroin trying to make the two worlds come together.

So you see, I'm not the only athlete that has had problems with alcohol and drugs. But there are many problems outside of alcohol and drugs, and I think that many of these problems lead to the abuse of alcohol and drugs. But I want to say that I am one of the more fortunate ones. I have had a bout with alcohol and drugs, and I have overcome it without dying or ending up in jail.

More importantly, I am able to give something back to the community. I am grateful for the many wonderful things that have happened to me in my life. And athletics has been one of them. I made mistakes that were very, very costly, mistakes that I hope never to make again. My involvement with cocaine certainly ended my career prematurely; caused me tremendous financial and personal loss. But these problems are behind me. And any human being that has lived for any length of time has made at least a few mistakes, but it is not, however, the mistakes that are so important, but what I have learned from them that I can help other athletes, male and female athletes to avoid repeating them.

Athletes actually become addicted to the sport. It develops a syndrome called Hero-lism. And the only way to prevent it is to make sure they are prepared to walk away from athletics. Five million

young people fighting for 500 spots, pro athletes live in a fantasy world where from the age of 14 or so they have been taken care of.

Reality is that athletes have 24 hours in each day the same as anyone else. And when they are not playing their sport or playing the role of a hero, they have to find some way to fill their time. A lot of them fill their time doing drugs. Once you get hooked, it is hard to get off. It is hard to get off of sports. It is hard to get off of drugs.

Again, my personal experience has been the teacher. And I know that chemical dependency or addiction to any drug, especially cocaine can be a killer. Chemical dependency is our Nation's third leading cause of death. And to some extent we are killing many of our young athletes by denying them the ability to get the help that they need and deserve for their problems with alcohol and drugs.

My strong feeling is that we must create new educational programs that will help us to establish our youth on a firm footing in life, a firm footing that will preclude the need for mind altering substances. Some examples of programs are:

One, establish a USAA chapter in every U.S. high school, every college, every university.

Two, teach athletes the laws of sports: prepare for early retirement, learn how to maintain your mind and body at optimum fitness; learn techniques for improving professional skills; learn how to live a balanced life; put sports into perspective.

Three, establish a college curriculum that will educate the athlete in the areas of: financial planning and responsibility; leadership, what it requires of you and how to meet its challenge; how to meet and respond to the public; life balancing, how to structure your life outside sports; principles of stress management, how to cope without crutches.

Fourth, professional teams should show leadership in preparing a plan for returning athletes to the community in some productive capacity after a sports career.

Five, establish a National Institute of Sports and Humanities, which would serve as a think tank for coaches and athletic administrators to research moral and ethical issues of professional sports as part of the American scene.

Six, include professional athletes on all committees, advisory bodies, regulatory or governmental commissions, college and university policymaking boards, so that they can provide input into the resulting rules and regulations affecting them and their careers.

Your help in bringing this to pass will result in thousands of lives being reclaimed for productive contributions to the American way of life and thousands more who will never become addicted.

[The statement of Mr. Eller appears on p. 65.]

Mr. RANGEL. Mr. Eller, that was a constructive, informative statement with some sound recommendations, and we are deeply appreciative for it.

We are joined by our colleague from New York, Congressman James Scheuer, author, legislator, and nationally known fighter against drug abuse.

Our next witness is Bernice Carrington, and we thank you for courageously facing the committee today.

TESTIMONY OF BERNICE CARRINGTON, WASHINGTON, DC, BANK EMPLOYEE AND 9-YEAR ABUSER

Ms. CARRINGTON. Good morning, committee, and it is an honor to be here today, and I want to thank God for allowing me to be here and to be absent from any chemical or alcohol.

I am an alcoholic and drug addict, but I am in a recovery program today. If it wasn't for the programs, the facilities, during the time near the end of my addiction, I wouldn't be sitting here today.

I can't blame my family. I can't blame anyone for my addiction. It is just something that happened to me as a human being. And I do not question it. I used to kind of look at it from a point of view I was from too large of a family or maybe because my parents divorced or there just wasn't enough money. But I was able to see it from a different point of view later on in life as I got involved in a recovery program.

I drugged to live, and I lived to drug. My progression of my drugging started when I graduated from high school. There was a lot of peer pressure. I wanted to fit. I was a very inadequate, insecure human being. I wanted to grow up fast and be in that limelight. As a result of that, I followed negativity all the way and as a result of it, I became addicted.

I realize I have an addictive personality. I am addicted to people, places, and things. After going through the downfalls of being an addict, I qualified to sit here today because I was placed in institutions. I have been in jail. I have been in situations that I can't even mention here today. I have a scarred memory, but I keep it up front to remind me where I came from.

I am a little nervous today because this is not something I do on a daily basis, but that is good for me, because when I was practicing, it would be nothing for me to dress up and put a skirt on. As far as being a female, it was very hard for me, because during the times that I was practicing, there were no facilities where I could walk in and ask for help.

There was always a waiting line there. If I had to wait any longer, I might not be sitting here alive today. I tried different programs like the methadone system, and I abused that because it was a walk-in thing where I could take methadone and go back out and shoot dope again.

I played with that just to survive. I was physically, spiritually, and mentally at my bottom when I finally reached my bottom. I had the type of personality to where I would win people over automatically.

My encounters with the police at numerous times was as a result of me practicing. I would always run into the officer that would look at me and say, "Why would a nice young lady like you be involved in a situation like that?" Many a times I was let free, and I thanked the officer that finally told me, "When you act a lady, we will treat you like one, and this is one time you will go to jail."

I needed that time to get in touch with myself, to endure the pain, to really go through withdrawing, both through being left alone. I felt like I had no one that really cared about me until I got in touch with a recovery program. I found that if people like myself, other addicts and other alcoholics could teach me how to

live a new way of life—I have to unlearn and relearn an entirely new way of living today.

I had to teach myself how to drug. It was a progressive illness whereas cocaine is a cunning, baffling, and insidious disease. I do not consider myself cured today. I consider myself that the disease is arrested at this point. I do not know what will cause me to get involved again in life. All I can do is to contact somebody, if I have any feelings with that compulsion, to be able to identify with one who has gone through the same experiences.

I brought a child in this world that had a habit as a result of shooting heroin. You would think that this would really teach me something. I felt real bad and had a lot of resentment for the system. I had to be followed through the Federal Drug Administration; that it was a threatening thing whereas he could be taken away from me.

I got a real spiritual message that I had done that to another human being, and I thank God he is in good health today. I didn't just blossom up with a hype in my neck or arms. I had to teach myself that way of life and watch other addicts, watch what they were doing. And I wanted to be like them.

It didn't take long because you have to work on it. You have to unlearn the bad way of living and the new way today. I am a productive person in society today, because I stay close to these programs. I give back for myself as an example, a powerful example to other women, to other human beings that there is hope out here. I know what the misery is like, and what it is on the other side. It is only by the grace of God, because I came out of the bucket of blood. That is to say I have done a lot of things that I would not have done ordinarily if it wasn't for drugs and alcohol.

Cocaine allowed me to be anything, do anything I wanted to do. I was completely powerless. The compulsion was very great. I have had opportunities where I have tried to take my own life because of the insanity. The insanity that it allows you will make you do things that I would never do again—put a pistol in front of another human being's face, to hurt my family, my loved ones, not to even care, not even to care about myself.

I thank God that I have learned to love me today, to realize that I am the most important person today, to be able to go into these institutions, these hospitals, and to participate as far as giving back what has happened to me in the hopes that it might help another addict. I do this on a daily basis and I am the greatest benefactor.

I don't have a real long, lengthy speech, and I am going to really close with thanking you again for allowing me to tell my experience, strength with hope that the message will be given, whereas more institutions, and more detox centers will be opened.

When people need help and don't know how to ask for it, they will be able to get help today. With that, there is some hope. Thank you.

Mr. RANGEL. Ms. Carrington, you are a very powerful witness, and we appreciate you sharing your experiences with us.

Before I question, I would like to acknowledge the presence of Frank Guarini, from New Jersey, who has joined with us, and Solomon Ortiz, from Texas.

Ms. Carrington, what was it, or did I miss it, that caused you to turn the corner to seek a different way of life after you were involved in drug abuse?

Ms. CARRINGTON. I came in contact with people that I practiced with that were involved in programs, that had gotten their lives together that stood there and held a corner down like myself. I looked at them and they looked good to me. I wanted to look like them, so I followed practicing what they did and it helped me surface from the misery that I was in.

They were a powerful example because I did not want that way of life anymore. I had finally reached my bottom.

Mr. RANGEL. Well, you have put your life together, and you are involved professionally now, but you touched on trying to help other people.

What are you doing in that area now?

Ms. CARRINGTON. Right now I am a former chairperson of Second Genesis. I go to Lorton, maximum security, et cetera. I was in this room last year, and I was presented a correctional award for participating as a volunteer. And I go into hospitals because I mean there are certain areas right here in the District of Columbia where they have meetings for addicts and bring people that have something to give back, that might help somebody. And I am actively participating in that presently.

I deal with the CADAC Program at St. Elizabeth's Hospital.

Mr. RANGEL. I am not going to subject you to any further embarrassment, but I have had the opportunity to review your criminal record, and you are indeed a miracle of rehabilitation, and we thank you for your strength.

Mr. Keach, thank you for coming forward and allowing us to break through the mystique of your profession. When you are going over a script for the producer or the director, and you see in that script the casual use of drugs, whether it is cocaine, marijuana, or heroin, in the story that is going to be presented to the general public, it is just one recreational activity with no stigma attached. Are there any rules, or guidelines, or anyone that an actor like you might, say, would this pass whatever?

Mr. KEACH. Well, Mr. Rangel, I would say in the past 18 months or 2 years, we have witnessed in Hollywood a tremendous change, a real turnaround in terms of the whole stigma of glamorizing drugs. Today, it is considered not only in bad taste, but I think it is absolutely irresponsible to condone the use of drugs, and certainly in television. In most pictures, it is a different situation, because I think that while I recognize an artist's responsibility to reflect what is going on in society, there is also a responsibility to provide positive role models for people.

I don't think that we are playing with the same kind of glamour abuse as far as drugs are concerned in television. Today we are discovering that, certainly in police shows, the drugs are considered to be taboo. In fact, it has gotten to the point where they don't even become an issue so much with plots because they are so difficult to deal with.

There is the danger that you can actually glamorize the use of drugs by condemning them in certain ways if you are not careful.

Mr. RANGEL. But these restrictions are self-imposed. There are no codes that you have to really abide by in terms of scripts presented to the general public?

Mr. KEACH. It varies from studio to studio, network to network. Basically speaking, you are right. There are no general codes, no. I think that within each network and within each studio codes are being developed even as we speak.

Mr. RANGEL. Thank you. I have so many other questions. We are restricted under the 5-minute rule, but I do hope that all the witnesses might entertain questions that may be forwarded to you after the hearing.

Mr. Eller, you describe athletes as being addicted to the sport as well as sometimes drug abuse, and no question, our young people playing basketball—that we can feel that addiction. Are there any restrictions that the use of drugs would place on your physical ability to perform?

Mr. ELLER. Well, quite honestly, Congressman Rangel, what happens with professional athletes is that they practice their skills and become so proficient at it so as to detect any deterioration in their performance comes at a much later stage in the illness and therefore many of them are able to go undetected even if they begin at the younger age.

The younger an athelete is, the more detrimental it will be in developing those skills, but once a person has become a professional athlete, they are pretty proficient and can perform at an acceptable level far below their potential. Their physical skills are only noticeably affected in the later stages of the illness.

Mr. RANGEL. Mr. Gilman.

Mr. GILMAN. I want to join again in thanking our panelists for their willingness to come forward, and to be frank, and candid. We are here to try to find better ways of approaching and finding this problem here in our own region and throughout the world also.

What recommendations do each of you have for more involvement by the Federal Government in trying to stem the use and flow of cocaine? I welcome hearing from each one of you. Mr. Eller.

Mr. ELLER. Congressman Gilman, I appreciate the opportunity to make my suggestion. As I believe the athletes are being cut off from getting help basically because they have a tremendous responsibility to provide this heroic image that society has placed on them, even at the young level, they take this responsibility which is actually a burden on them, because they do not seek help for their problems. And this is a detriment to their own personal health and to what we are trying to accomplish.

Something like the United States Athletes Association which is a conduit for these young athletes to talk to each other about their problems and have peer association, develop positive living skills, and get recognition for it. The same appeal of drug addiction goes both ways. The U.S. Athletes Association is a positive way to get recognition. Drug addiction is a negative one.

People want recognition and they want to be appreciated and recognized for what they do. Those same motivations apply to negative and positive responses. The U.S. Athelete Association is a positive respone.

Mr. GILMAN. Is there any activity at all in the U.S. Athletic Association to move in this direction?

Mr. ELLER. We are a new organization, and we have formed some chapters in Minnesota, and a program is being started in North Carolina and hopefully in Pennsylvania later this year. But we would welcome the support and the commitment of the Congress and this committee in supporting this organization.

Mr. GILMAN. Are you active in the organization?

Mr. ELLER. Yes, sir, I am. I am one of the founders of the organization.

Mr. GILMAN. We certainly welcome a little more material with regard to what you are doing and how best we can be of help to you in that area. Is there any other area in which you think the Federal Government can be of help?

Mr. ELLER. Yes; the Federal Government can be very helpful. What we are trying to do is make it popular not to take drugs. The rights of passage is a tremendous influence on the adolescent, the idea of being an adult, the idea of being a responsible person. Being able to handle alcohol or drugs has a tremendous influence on our young people when they see adults use chemicals. We need to establish a guideline early in life that you can be a positive and successful person without drugs or alcohol, and you can have fun.

We need to promote that image, and we, as adults, parents, need to provide this example at every level by being role models for youth in our homes, schools, and communities.

Mr. GILMAN. Thank you. Mr. Keach, I welcome your thoughts also.

Mr. KEACH. I second what Mr. Eller just said. The Federal Government can be very instrumental in continuing to support the States and their localities to develop programs like the Employees Assistance Program, the DARE project, which is one of the most innovative projects, where you actually have police working in conjunction with the board of education to teach fifth and sixth graders to say no; resist peer pressure.

They need financial resources so I am very much in favor of bill 526.

Mr. GILMAN. Can we discourage the use of narcotics?

Mr. KEACH. The continued discouragement concerning the use of drugs in television is a positive move. I don't think it is going to be very successful in the motion picture industry unless certain codes and bylaws are established because the fear of censorship would be very strong among certain producers.

Personally, I think that the kind of testimony we have heard today will encourage people to take a different point of view toward how to reflect the use of drugs in films.

Mr. GILMAN. Several years ago this committee went out to Hollywood and attempted to encourage the industry to adopt some rigid guidelines and we were citicized for being on a witch-hunting expedition. I would hope that somehow with your leadership you can encourage the industry to undertake some volunteer steps.

Mr. KEACH. That is certainly possible, and I hope so too. We are just beginning to see new organizations like the entertainment industries counsel for a drug-free society, and the programs existing

within the networks. They are relatively new programs, established last year, so it is a fairly young thing to happen.

Mr. GILMAN. We hope it spreads out and gets wings at an early age. It is the impression of many of us in the Congress, that the industry, both in sports and the entertainment field, have a responsibility to voluntarily undertake more stringent steps than they have in the past, and I hope the leadership of both of you can encourage that type of movement.

Mr. KEACH. We are beginning to see, not necessarily in the area of entertainment, but in the area of documentary film-making, for example, Capital City's Production is doing a project under the direction of Mr. Charles Keller on the effects of cocaine abuse. I am proud to be participating in that.

Mr. GILMAN. They are certainly effective. This committee just viewed the "Snow Storm Over the Amazon," by Jaques Cousteau and his son, and it was a very effective piece. And my time is running.

Ms. Carrington, would you care to add your thoughts?

Ms. CARRINGTON. We need more programs. We have more addicts. We need more facilities for the female and programs to go into our institutions.

Mr. GILMAN. What kind of facilities for the female are you suggesting?

Ms. CARRINGTON. Facilities where women can go, as far as seeking help for their problems with alcohol, et cetera. They have a hard time coming out of the closet.

Mr. GILMAN. Where did you go for help first?

Ms. CARRINGTON. Project Adapt in Baltimore. I learned it from the street because other addicts were using methadone at that time.

Mr. GILMAN. Had it ever been suggested by court or police personnel to go to one of these agencies?

Ms. CARRINGTON. No, it was not.

Mr. GILMAN. Thank you.

Mr. RANGEL. The Chair recognizes Larry Coughlin from Pennsylvania.

Mr. COUGHLIN. Thank you very much. Let me commend the witnesses and extend my appreciation for their testimony here.

Sometimes I believe that I sound like a broken record before this committee in expressing the belief that we spend an inordinately high percentage of our resources on the supply side of drug abuse, on interdiction and combating supply and not enough on the demand side. There is such big money in supplying drugs, that if the demand is there and there is not adequate treatment and rehabilitation, the supply will always be there.

I would like the comments of each of you on, first of all, how you feel about treating the supply side versus the demand side; what resources we devote to what; and how easily drugs are available. Are they not available easily from a supply standpoint?

Mr. ELLER. Congressman Coughlin, I agree with you, and I know that the person that I look at that makes the most profound statement on drug and chemical control is William Burroughs in his book, "The Naked Lunch." What he says is that we really have to get rid of the need and that is simply all he is saying. As long as

that need is there that there will always be a supply and the need, of course, being the demand.

I know from my own experiences the things that I would do and the amount of turmoil that I would put myself through in order to get some drugs. There is nothing that could stop you from getting that high, so I believe with the amount of money that we are putting in enforcement, I know that it has been effective. I realize you have to work on that side, but until people understand the addiction and that they can go get help and until that help is available, they will not realize where they are heading and before they get to that point of being addicted.

Then I think it is certainly the demand side is holding its grounds and will continue to do so. More prevention programs are needed. We need to spend more money on getting rid of the need.

Mr. COUGHLIN. Mr. Keach, you talk about prevention, recognition, rehabilitation. Could you comment on the same thing?

Mr. KEACH. Thank you, I don't feel qualified to discuss the supply side in terms of statistics. I know we do spend a tremendous amount of our resources in combating the supply. I agree with what you said. The supply is always going to be there.

It is a matter of how you deal with it. I would like to see the priorities on the demand side at least reach an equal level.

Mr. COUGHLIN. Ms. Carrington, could you comment on the availability of drugs to an addict and the extent to which an addict will go to obtain them?

Ms. CARRINGTON. It is not hard. It is very accessible. If I wanted to make a buy from leaving the hill, I could.

As long as there is a surmountable amount of addicts, it is no problem obtaining any type or amount of drugs. I don't see anything lessening in the area of being able to buy in quanity, you know, so it is there, the availability. Trying to restore that human being back to sanity is the most important factor.

Mr. COUGHLIN. Did you ever receive, before you became an addict, any drug abuse prevention education?

Ms. CARRINGTON. No, I did not. This was in the early sixties and seventies.

Mr. COUGHLIN. Would you recommend that our schools have compulsory drug abuse education?

Ms. CARRINGTON. Yes, I do.

Mr. COUGHLIN. Thank you, Mr. Chairman.

Mr. RANGEL. Clay Shaw of Florida?

Mr. SHAW. Thank you, Mr. Chairman.

I would like to compliment you as the ranking member for having this hearing today.

All of the witnesses mentioned the peer pressure and all of them got caught, and all of them have told us that we should look for methods of bringing help to people without them having to undergo the humiliation of being caught, tried, found guilty and having to serve the time that society requests of those who violate our law.

I would like to follow up on the supply question. This is a very important question. I feel that the demand is somewhat created by the ease of availability.

Mr. Keach, are these things available readily on movie sets? Can you go on a movie set and make a buy?

Mr. KEACH. It is no more available on a movie set than it is in the school yard.

Mr. SHAW. Then it is available?

Mr. KEACH. It is available everywhere.

Mr. SHAW. The same thing as to the locker room?

Mr. ELLER. It is available maybe with some slight difference. In Mr. Keach's profession, entertainment, a very glamorous, generally thought to be very lucrative profession, very similar to the athlete. As an athlete, I always felt I was more approachable because I did not present a threat. I was a known public figure that they could come up to without fear that I wasn't going to slap a set of handcuffs across their wrist and so they come to me.

There is a certain benefit in being associated with me many professional athlete, whether I was a friend or not, if they knew me. They had been at a party with me, or seen me, they could tell that to another friend. It helped them in their marketability of their product, selling drugs to their customers.

Mr. SHAW. Both of you are to some degree the role model for young Americans, and also people of our generation. We like to watch you on the field and on the television. I am particularly a fan of yours having watched your television series, and one thing that I notice, you would always have a struggle between right and wrong, and you always would know that right would prevail and the plots were not so complicated that you would have to scratch your head afterward to figure out what really happened, because the message was very clear.

That is what is particularly disturbing to find that people in your professions, or our profession, lawyers or doctors or any others, to see when you get involved in something like this it is either a crushing blow, or it would relate to the American people that maybe cocaine isn't so bad. So this is something that my role model does.

What can be done within your professions? You have a great responsibility. You live in a glass house, as we do, and I think you have a great responsibility to police yourself and to see what can be done. I would like to ask you, Mr. Eller, do you believe that urine tests or various other examinations should be submitted to players, professional athletes?

Mr. ELLER. What I think, Congressman, we have isolated the athlete to a great extent already in our society. And I think part of this pressure, this burden of responsibility to be a role model is a source of anxiety. And unless they are taught to handle this pressure without drugs, they will continue to use them. That anxiety creates comes from being set apart from the rest of society a stress that is sometimes subdued by chemical use.

I think by testing them, you increase their stress. You increase this pressure and further isolate them. I am not opposed to testing athletes, but I am opposed to testing athletes in the sense that they are not part of society. I think if you do test them, you must test these other professions as well, entertainers, lawyers, doctors, and so forth. Then it is fine. But again to set them up as a special and separate group from society, which has already been done, then it is a mistake, and that happens not only at the professional level,

but many of our young high school and college athletes feel this pressure also.

Mr. KEACH. Congressman Shaw, I would certainly hate to see the day when we would all have to be tested to see whether or not we were drug free, but I acknowledge the problem. I acknowledge that we have to do something about the situation, and I hope that we never have to see that day, because I do think that it is, in many ways an encroachment, a violation of civil liberties.

However, it is a great encroachment of liberty to be drug dependent. I don't have an answer. I hope we don't have to get to that extreme, that's all.

Mr. SHAW. Let me follow up for just a moment. We are seeing a great deal of these videos, and the young entertainers, the singers, are singing about drugs making it almost permissible. Don't you think some type of self-policing should be in the entertainment field, because of the extraordinary amount of impressionism that we have out there?

Mr. KEACH. I don't feel qualified to talk about the music industry, but as far as dramatic television shows or motion pictures are concerned, I do think we have a responsibility, but I think that the kind of testimony that we are hearing today and the kind of awareness that we are talking about will hopefully cause people to pick up their ears without having to get to the point of legislating laws that, I think would encroach on our freedom.

Mr. SHAW. My time has expired. I think your presence here will do a great deal to bring about the type of peer pressure that we need. Thank you, Mr. Chairman.

Mr. RANGEL. The gentleman from the District of Columbia, Walter Fauntroy.

Mr. FAUNTROY. Thank you, Mr. Chairman. Let me commend this panel for fashioning for millions of Americans at this hearing an instructive example of the fact that you can overcome addiction.

One of the major problems that I have encountered has been the fact that people feel, "once I am hooked it is over," and you have, by your very presence and by your determination, transformed that belief into hope for millions of people. I hope that those who see you will see you as human beings, as we see you. You are people who decided that you were going to lick this thing, and for that I want to thank you.

I have two questions, Mr. Chairman. The first is for Ms. Carrington, and it has to do with this "right of passage" idea that so many of us get involved in because of peer pressure. Against the background of your experience, and talking with others who have been similarly addicted, what ought we to be doing to deal with this "right of passage" idea that somehow, you prove your manhood, your womanhood by getting involved in drugs?

What would you say to us?

Ms. CARRINGTON. The power of examples that we need to see today, for instance, like myself, you know—I consider myself a miracle. That is the reason that I participated in the facilities and the type of work of giving back—that someone can see through me a way. The same example that I show to my son, you know, once upon a time, I wouldn't have wanted to be the way I was, but now it is OK, showing the power of example, as far as peer pressure,

not drugging, being able to say no, still wanting to make something of yourself.

If a human being really wants to do something about himself and has the honest desire to want to live, and they know that drugs and alcohol will only give you three things and that is institution, hospital, and death, pain will let them know. And a power of example, good examples, instead of peer pressure is the only way. Thank you.

Mr. FAUNTROY. Mr. Eller, you have emphasized the importance of education in your area, that of athletics. You pointed out to us and for me a new idea, that young athletes need to be educated about handling the pressure of being a role model. And you pointed out that young athletes need to be educated about the harm of drug abuse and if they are into it, to ask for help early on, without threatening their future careers.

You pointed out that they need to be helped and educated about the perils of herolism which gives them the idea when they are really roaring, "I can do anything," and "I can handle it." You pointed out the need for preparation in handling the second career, the coming down off of the athletic career into an every day world.

One of the things about drugs among athletes that puzzles me—baffles me really—and I want you to help me understand. As I reflect upon my own youth, the thing that helped me handle peer pressure was the idea that to be an athlete you have to take care of your body. You have got to be alert, to get in shape, and so you don't drink and you don't carouse. You want to perform well. What happened to that? Where did this goal—how did this goal—get lost in athletics?

Mr. ELLER. Congressman Fauntroy, I, too, grew up under this same type of a concept, and that is certainly changed over the years. The idea, I think, prevails that the athlete is a healthy type of person. But the conflict in the average high school in America now is, if you are not involved in drug culture, you are not with it.

Let me explain my concept of herolism. Herolism is a chronic disorder characterized by an overwhelming need to play a role, maintain an image or continue to perform an act or event which is essential in achieving a personal sense of value; the development of a false-self to meet the expectations of others.

The athletes that I deal with, when they are confronted by the other students, they ask them, why are you doing this? Why don't you go along with us, and we will have some fun? Why aren't you into drugs? It is senseless to make this kind of sacrifice. What are you going to get out of it? There is a tremendous pressure to get the athlete involved in that drug culture, and we need to reward them for the positive behavior and say to those guys who are not involved with drugs, "Hey, this is great. We really appreciate what you are doing."

We have a very, very small number of professional athletes involved in drugs. It is much, much different than earlier perceived. The image has been changed by the few that have been caught up in the drug problems, and that brought the attention to the national public of drug abuse.

Mr. FAUNTROY. Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Scheuer from New York.

Mr. SCHEUER. We all enjoyed your testimony and we all appreciate and respect the role models that you are playing now. It is clear, however, our society can't afford to put all young people through a prison term in order to concentrate their minds on rehabilitating themselves, nor are we ever going to have rehabilitation facilities for all of the kids in America, assuming that they are all going to be seriously involved.

We have got to get involved in some kind of prevention. We got to turn kids away from drugs before they get involved. Heroic as your conduct has been, once you got into it and hit rock bottom in each of your own lives, there has got to be a better answer than that for the millions and millions of American young people who we want to save. It has to be self-exhausting.

The income tax people can't have a major investigation of every single taxpayer. There has to be a national consensus. We need a national consensus among kids that drugs are a no no. What can we at this level do? What ingenuity, what resourcefulness is called for by legislators here in front of you or our peers at the State and city level that would set up programs, incentives, whatever you want to call them, that would turn kids off of drugs before they get involved?

That is what we have got to do. I would like it from all three of you, if you have any ideas.

Mr. KEACH. I was going to say we are being slightly redundant, but I think it is important. The national PTA drug abuse project is now finding various programs that are the equivalent of the employee assistance program with students, where the students themselves actually take the responsibility and the initiative to teach their peers to stay away from drugs.

Those programs I don't think require financial resources. I think they require encouragement from the Federal Government.

Mr. SCHEUER. They are done in the schools?

Mr. KEACH. That is right.

Mr. SCHEUER. In what hour, social studies?

Mr. KEACH. I am not sure. I do know, and I also know it is not being done in all of the schools, but I think we should reach out and tell people everywhere across this Nation, at all of our schools, that is the place where education has got to start, and it can start with the students themselves.

Mr. SCHEUER. Mr. Eller?

Mr. ELLER. Yes, Congressman. Again, I think that the programs that have been mentioned here and there are many, many, and are very worthwhile. I feel very strongly about the one I am involved in, the United States Athletes Association, because I do believe that the athletes need this conduit where we can achieve this recognition and be the leader in the fight against drugs.

I feel a responsibility to be a role model, but I think I can fulfill that responsibility much, much better now. I know that I do, and it is for the simple fact I know how to handle the problems in my life and the stresses that I confront without using drugs to do it. Life has not changed so much that I don't have problems now, because I am not using drugs. The fact is I now have the tools in order to handle those problems.

We need to give those tools, particularly to athletes or ones that are aspiring to be athletes at a younger level because that pressure is there for them. You can have many, many rules and this is the way many people approach the drug problem in athletics; stricter rules, more policies that aren't going to work without the personal skills to go along with them.

I believe that if the person, whether an athlete or not, if they feel good about themselves inside, feel confident and can handle themselves, it doesn't matter what the rules are. They can handle almost any situation, even when confronted with drugs, and that is my philosophy. They must get to know themselves, too—not just the rules.

Ms. CARRINGTON. I agree with Mr. Keach as far as in the school system, the students relating to the younger students. This is a great idea. That can also be carried over. I mean older students, pardon me, relating to younger, right. And also the same way of relating and identifying can be used in our boys' clubs, you know, in our community centers and places such as that.

Community-based programs, like when school is out, there is a recreation center where children can go and mingle with people, other children they can relate to that are not going to give them anything negative; that can show them positive things and teach them the right way, how to say no.

It is all following a role model type pattern. I had to have someone inspire me or to relate in order for me to get the message. Thank you.

Mr. RANGEL. Thank you. Mr. Ortiz from Texas.

Mr. ORTIZ. I am certainly very happy to have you as witnesses to appear before this committee.

One of the questions I would like to ask, I don't know how to ask it. When you were using drugs, what was the thing you feared the most; that you would develop health problems later on because of the usage of drugs, or the penalties that you would be incarcerated? Was there any deterrent that you feared?

Ms. CARRINGTON. I experienced the entirety except for death. I OD'd, and I have faith today, because I am alive today. As far as the law and the system, that also allowed me a certain amount of pain because I was incarcerated. I was helpless. It kind of gave me a learning experience.

I dealt with the physical aspect of change where my body deterioriated. I became dark complected. My teeth got soft. I lost a tremendous amount of weight. Cocaine results in making you melt away. My nervous system was—I had a nervous disorder as a result of practicing with cocaine.

I was put on depressants as a result of that which is only one drug treating another, which didn't make matters good for me at all because it was only keeping me participating with another chemical. But I couldn't do it alone. I feel like it is very important that people who need people are the luckiest people in the world. People are the reason I sit here today and through God. He works through people. Thank you.

Mr. ORTIZ. Thank you. Mr. Keach.

Mr. KEACH. One of the terrible things about cocaine is that while you are using it, a lot of times, as I said in my statement, you feel

that you are on top of things, in control of the situation, and it doesn't offer a deterrent in and of itself until it is too late, until you realize that suddenly the only way you can get over these feelings of anxiety and depression is by taking another hit.

And that is the terrible part of that. When you begin to realize that you are hooked, a lot of times you are unwilling to admit it or do something about it until somebody stops you. And that is why we have to continually educate people to this, so they won't get involved with it.

Mr. ELLER. Yes, Congressman Ortiz, I think that my biggest fear during the time that I was using was that people were going to know; that people were going to find out.

It was a tremendous blow to my ego. That was the one part of my identity that I wanted to protect. The cocaine use probably presented many symptoms of paranoia. I was paranoid of being arrested all the time, daily, because I was either in possession of cocaine, either on my person or on my premises. Once you become an addict, you are never without it, and it is amazing how an addict can function in our society.

Many opportunities were there for me to be incarcerated. I prided myself of being able to evade some type of apprehension that would lead to incarceration. I am a lucky person, quite honestly, to not have gone to prison, and I am grateful that I am able to be here and do what I am doing today because maybe if I had this opportunity earlier, that might have prevented me from going on and becoming more involved with drugs and suffer as I did.

If I had been encouraged to say I can seek another lifestyle because once you get into drugs, that is it until you got something that is going to draw you out. You have to have something that will bring you out, offer you the same or equal incentives or rewards.

Mr. ORTIZ. The reason I ask this question, I do have a drug education bill for 1985 which will help the local school districts implement a program. What you are telling me today is once you are hooked, you could care less about any deterrent, whether it be a jail sentence, your health. Once you are addicted, there is not much you can do to really quit. I guess a drug education bill at the local school level maybe at the elementary school will help and I believe this will be about the only thing that will help prevent a young student from becoming an addict.

I say this because I was the sheriff of my county for many years. Do you think a drug education program at the elementary or junior high or kindergarten level will help?

Mr. KEACH. Unquestionably, I think it would.

Ms. CARRINGTON. Yes, I agree with that because this is a new age of human beings coming up, and the younger, the better. Thank you.

Mr. ELLER. Let's not just depend on the person that is using the drugs. Put part of that responsibility on his peers and people that he associates with.

I think that I got help simply because there was somebody there that recognized there is a problem, and they cared enough about me and said, "Hey, we are not going to accept that." You have to have people to confront those people who use drugs. Very few

people get help on their own once they are hooked, but if somebody is around them, they will say you got to go get help. Then there is a better chance the person will be helped. Or, if they were to confront that person before they stated using drugs it would be better still. Having alternations to drug use is a powerful prevention method.

Mr. ORTIZ. Thank you very much. My time is up.

Mr. RANGEL. Mr. Frank Guarini, one of the hardest working Members of this Congress and certainly of this committee in fighting drug abuse.

Mr. GUARINI. Thank you for those kind remarks.

I want to commend the panel and thank them for their very impressive and helpful testimony. You have got a great deal of courage, and you have given your living experiences to the Nation for their benefit. I assume that from everything that has been said, there is no one answer. We need education, interdiction, getting rid of it at the source, health care research, and so many facets to approach the problem.

We talked about the school yards and the playing fields, and we know corporate America has been very much affected by it, and we know that there is a tremendous rash of cocaine in Silicone Valley, and we know it affects our national defense, high technology, and we know also that it permeated our military.

We did take effective means of wiping it out of our military, or at least greatly reducing the problem that we had in our military. And that was by giving tests, although I know that there is perhaps a constitutional question about their legality. Nobody likes tests.

Is there a responsibility on the part of the commissioner of baseball, football, basketball, and maybe a corporate responsibility in the movie studios and throughout the rest of corporate America to take some active steps to see that it is wiped out where they have jurisdiction?

We know that it has been successful in the military. Should we use this as a model for trying to attack cocaine from the other part of our nondefense effort, which is our domestic effort here?

Mr. KEACH. I would say, Congressman, that the only way that that would be effective is if we did it with every member of our society and not simply isolate sports and the entertainment industry.

Mr. GUARINI. Hasn't it permeated every ethnic group every economic level, every age level of our society? Haven't we gotten to the point where we are in a war against this drug abuse?

Mr. KEACH. No question about it. We are definitely at war, but the question I have for you is, What, or how would you go about testing everybody's urine for drugs?

Mr. GUARINI. Well, let me ask you, should there be a little emphasis on the user of the drug as a deterrent?

We arrest drunks, and true, he may be an alcoholic and find out he needs treatment, and we help him. Isn't this the same kind of situation where there is abuse of a substance, and if he needs medical help, would you give him medical help? But if he infringes on other people's rights in society, if he drives the car and imperils the highways and our constitutional rights are affected, if he runs

into us, because he is an irresponsible driver—isn't the level of performance of a person driving a car impaired under the influence of cocaine? Should we put some emphasis on the user, to use that as an additional deterrent?

We go after the traffickers, the dealers, and put the emphasis on that part of it, but the people who really are subjected to this terrible drug, should they bear some responsibility, too? Should there be criminal penalties against users? And that is my question.

Mr. ELLER. The courage of the panel is very commendable. I want to talk about the courage of the committee, because I think this is courageous what you are doing.

If you are saying that this problem has become so pervasive; that we need to take this sort of measure throughout society, then I would agree with that. And I also would agree with the fact that Mr. Keach says let's not isolate any one segment because I don't think that any one segment bears this responsibility anymore than the other, and that is my only hesitation.

Penalizing the user, we realize it as a health problem, but if someone seeks help for their health problem, that is OK, but if they in fact go beyond that and commit some crime, they have gone beyond a health problem and should be punished, but not before.

Mr. GUARINI. Should we lionize Richard Pryor who admittedly got involved with drugs and uses it even as a vehicle for great fame and glamour? I want to give him a great deal of credit for having licked the problem, but still, by the same token, it doesn't seem to be a deterrent to other people if they see even more and greater success is attained after they run through these kinds of problems.

Mr. ELLER. Maybe this is where we can solicit the media, because any person that has been addicted, and I am sure my other two partners here will agree with this, you don't come away unscarred. What you have is a killer, and I have not gotten away scot free. Nor does anyone who becomes an addict. I had a professional career, but my career without drugs would have been much more beneficial for me, and even Mr. Keach's career without his prison sentence may have been more profitable.

You don't walk away scot free and if we could solicit the media to talk about the harmful effects of drugs, the penalties and what happens to these stars who become addicted. It is an illness, not just some weakness in their personality. This is what the illness does to everybody even athletes and stars.

Mr. GUARINI. Do you have a message for the media as to how they handle this drug abuse problem in reaching the public?

Mr. KEACH. More is better in this case. The more we can talk to people, the more our message can be delivered to people, the more consciousness we are going to raise. That is my feeling.

Ms. CARRINGTON. I don't believe in everybody being penalized for first offenses with drugs. I mean, as far as your first statement, you would have to build more institutions. People have to be willing to do something about their lives. This takes some encouraging because a lot of people suffer from very grave emotional disorders as a result of drugs and they need the forewarning to be offered the help and to want help at the same time.

I can identify with people myself that can be repeat offenders, because they are not willing to stop. You have to have that within yourself; that little voice within you to want to do something about your life. Whatever the costs, the pain, the emotional scars, that there is the pain that you suffer that will make you come to your bottom and make you do something about yourself.

The RANGEL. Thank you. The chair recognizes John Rowland, the Congressman from Connecticut.

Mr. ROWLAND. I, too, join my colleagues in thanking you for your interest and concern in probably one of the most important problems facing our society. I have got a parochial problem, and we have evaluated some of our educational programs, PTA programs, but there is also a group of people in our society, if you will, that are going to be hard to get to, and those are the people between the ages of 20 and 35, the people we refer to as yuppies, or the baby boomer generation or most recently referred to as the new collar generation.

These are people that I find to be very competitive, interested in climbing the corporate ladder, people that are health conscious, and people that are really wanting and wishing to succeed.

Mr. Eller used an interesting term. You talked about the subculture. Do you feel that this new collar generation has stepped into the problem of cocaine use and is it a small subculture of that group or is there the possibility of this whole new generation getting sucked into drug abuse problems in spite of all the other things that I referred to?

Mr. ELLER. I think there is a particular problem with this new generation becoming involved with cocaine because it is hard to differentiate those feelings of being an aggressive, ambitious creative person who makes it on your own abilities, to be able to separate those feeling from that of a cocaine high. It is a tremendously enticing, complicated type of an illness. It enhances the own personal ego. It reinforces all of those self-fulfilling type ego gratifying behavior. They could become their own worse enemy thinking they are above it all when they are falling victim to its powers.

There is a new consciousness about this group, the health consciousness of wanting to take care of their bodies. If we could say to this group, this type of person that belongs to this group and the image that they are seeking and want to create means a drug-free lifestyle. If we can promote that idea, they can be the beautiful, successful person they want to be, and the only way to do it is without drugs. Then I think we will have the right image.

Mr. ROWLAND. If we can create the image of a drug-free society, make that as acceptable as wanting to own a BMW, we can combat the whole problem of one whole generation, sucked into the problem? Would you like to make a comment?

Mr. KEACH. I think you are absolutely on the right track, Congressman. That is the case. Implementing this also. We talked about the employee assistance program, but what about the unions? What about implementing it through the various unions, just offering this as a suggestion, and the unions may have a drug-free program that they may be able to get to their membership.

Mr. ROWLAND. Would you also estimate in a lot of cases in talking about cocaine abuse, that there is a little too much emphasis

perhaps on the peer pressure and maybe in these particular cases or if we see these as problems, it might be a lot of the individual pressures, insecurities and some of the problems of those aggressions and the tensions built up and trying to climb that corporate ladder?

Do you see that as being more significant than the peer pressure?

Mr. KEACH. Yes, I do, particularly with cocaine. Cocaine, this is a drug which enhances one's self confidence, to the point you feel like you can take on the whole world.

Mr. ROWLAND. Using the media, getting as much attention as possible, unions, can we deal with the corporations? Can we bring this problem to a head without giving the air that there is already a problem in existence to stop it from happening?

Mr. KEACH. The employee assistance programs, we should encourage more of that.

The RANGEL. Thank you.

The chair recognizes that we have been joined by Larry Smith who serves well on this committee and fights the problem on the Foreign Affairs Committee as well.

Mr. Smith of Florida?

Mr. SMITH. Thank you, Mr. Chairman. I appreciate the opportunity to be with you today and to take part in this. It is important that we understand the problem from all aspects and I certainly appreciate the candid statements of the witnesses and their desire to help other people, even though they subject themselves to publicity about something they are not as proud of as the rest of their careers, I am sure.

I have been fighting this problem for a long time in public and private life, and I am curious as to your reaction to a question. My question is to all of you, what would it have taken for you not to have gotten involved in drugs in the first place?

Ms. CARRINGTON. Well, Mr. Eller said it, you know, a positive image of society. If I had a positive image to follow opposed to the negative, then I would not have become addicted, I do not believe, today.

Mr. SMITH. Prior to the time that you became involved with drugs, started to experiment with them, did you have any thought or fear that you were going to be caught and did that fear have any overriding impact on you at all?

Ms. CARRINGTON. No, I did not.

Mr. SMITH. Suppose you had a fear that you were going to get caught, and you felt even though you wanted to use drugs, there was a very strong likelihood that you would be caught and punished; do you think you would have gone the same route?

Ms. CARRINGTON. Can an addictive person, as I was—regardless whether or not they promised the electric chair the next day, I would have still drugged when I was practicing, right.

Mr. SMITH. But there was a time in your life when you were not addicted to drugs.

Ms. CARRINGTON. True.

Mr. SMITH. At that point in time, the choice you made was voluntary in terms of drug use. There was a lot of pressure, I understand. It was a voluntary choice. Do you think your choice would

have been somewhat prescribed or your desire to entertain a drug life would have been diminished if you felt there was a strong possibility of being caught and a strong possibility that punishment would be rather severe?

Ms. CARRINGTON. I was aware of that. I understand quite well what you are saying. If I had someone that was positive, someone that could have inspired me to talk about what was going on within me, I probably would not have become progressively ill.

I did not know how to speak out and ask for help. I just continually was in the pressures of peer pressure, wanting to fit, not knowing how. And even though I realized there was going to be a penalty, I was always living in fear until after my addiction progressed more. I didn't even care.

Mr. KEACH. Congressman, it took my getting caught to quit, and that is why I would hope that that would not have to happen to other people. It required my actually getting busted to stop my use.

Mr. SMITH. You were not a cocaine user for most of your career. You are still regarded as one of the preeminent actors in this country and around the world. Was there a point in time when you made a decision to become involved? Did you give any thought to the consequences?

Mr. KEACH. No, I did not.

Mr. SMITH. There was no real overriding fear that you had of being caught?

Mr. KEACH. That is correct.

Mr. SMITH. Do you think it would have changed your entry into drugs had you had an overriding fear of being caught?

Mr. KEACH. I really don't know.

Mr. SMITH. Mr. Eller, I say the same thing to you, you are well-respected in the sports field.

I am not advocating this as solely the one approach, but I spent a lot of years watching educational programs, advertising, media campaigns, appeals to their senses, medical appeals, every form of peer pressure on the other side not to do it, and I have watched it as it has not been successful as we would like.

Do you feel that there would be a place for some form of, at the very least, fear to be instilled in young people, especially that there is a possibility and the likelihood of getting caught, and if that were so, would that have deterred you at all?

Mr. ELLER. I am going to answer that in two ways. One as a chemical user, abuser, one of the parts of excitment of cocaine is getting away with the criminal activity of using it. Cocaine use at one time was part of a subculture, I mean part of the high was being able to walk into a room or to conduct your daily activities without detection, beating the law so to speak.

It gave you sort of a mental satisfaction from being sharper and cleaner than the other guy, and was part of that delusion. So if the penalties are tougher this would have little effect without the certainty of getting caught. If I were to reflect to my prior using days, that there was not a certainty in that I would get caught and punished and that has a lot to do with the criminal justice system and the amount of deterrence in this kind of approach.

If we can assure certainty that if a person is going to use whatever the drug they will get caught, then it will have some effect. It probably would have helped me in my early stage.

Mr. SMITH. If somebody felt they were going to get caught and punished, it might have a deterrent effect?

Mr. ELLER. It might have. I don't know if the chemical user originally has a choice after this first use—his first use, something might have happened accidentally which could lead to addiction and where people would break the law to get chemicals, especially cocaine.

Mr. SMITH. I would like a yes or no. Mr. Eller, did you start with cocaine or did you start with another drug?

Mr. ELLER. I started with alcohol in high school and progressed to marijuana after college. The mid point of my professional career I got into cocaine.

Mr. KEACH. Exactly the same, same progression.

Ms. CARRINGTON. Alcohol, marijuana, all barbiturates, heroin, cocaine, everything except for PCP.

Mr. SMITH. None of you started with cocaine. Thank you very much.

Mr. RANGEL. The Congress and this committee are deeply appreciative of the courage that it has taken for you to come forward here. Now that you are addicted to fighting the problem, we will be calling on you.

We are working very closely with the National Advertising Council, and so we hope to be calling upon you to get your advice as to how we can reach out using your expertise in this field. We encourage you to encourage those people and in your peer group that are drug free to be proud of it in an effort to get that message out. And we will be putting in the Congressional Record our thanks for your involvement.

Before you leave, could I briefly get from each one of you the cost of your habits when you were involved so that we can get some idea of the financial obligations you had?

Ms. CARRINGTON. It is really hard to say right off the top. It varied. I really couldn't give you a level figure. I have spent, in the course of a day, up to $2,000 in drugs.

Mr. RANGEL. Mr. Keach?

Mr. KEACH. That is a difficult thing for me to do the same. Sometimes it would vary anywhere from $50 a day to $250 a day. It depended. I was not somebody who went out and bought a lot of drugs. I was just—I used them continuously, but in small amounts, but it didn't matter. It was a continuous period of use. It would be very hard for me to put a figure on it.

Mr. ELLER. The figure I have come up with is about a couple thousand a week. At one time, I was one of the higher paid defensive lineman in the league and at a salary of about $100,000, and almost my total income was going into chemicals, and so that is how I derived at that figure. That is basically where it went for a period of about a year or two.

Mr. RANGEL. Mr. Guarini wants to inquire. He wants to know whether religion played any major role in terms of breaking the habit.

Mr. GUARINI. Ms. Carrington, you referred to God quite frequently, and I know you have a new life. It has become very obvious from your remarks and statements.

We would like to ask the panel what role religion actually played in your finding your way back.

Ms. CARRINGTON. OK. To give you a real idea, religion was something that was forced on me when I was reared. It was like you had to go to church. My grandparents and parents gave me their God, whereas if I wanted to put an ironing board up on Sunday, they told me I would go to hell.

I never understood what God was about. I used to always call upon Him when I needed some dope, when my illness came down upon me and when I finally realized that there was a power greater than myself when I OD'd and I was able to survive that.

I knew it was something greater than a human being or myself. I was told to believe in other people until I chose a God of my understanding, what faith it was. I am a graduate from a parochial school in Detroit, MI, and I have a lot of religious background.

You have to believe in something today in order to make it and I did that, and I had to like do a lot of praying when I was coming through my later part of my addiction.

This helped me when nobody else was around, when there was nothing but me, God and the drug. I am not a very religious person, to where I go to church every Sunday but do thank Him every day from being free of chemicals.

If I die today or tomorrow, I will die with some dignity and not a dope fiend.

Thank you.

Mr. RANGEL. Mr. Keach.

Mr. KEACH. God has been very instrumental in my rehabilitation. I was raised a Christian but when I got involved in drugs, and got too egocentric, and concentrating on that, God became a lesser priority in my life, and that has been turned around.

Mr. ELLER. I believe God is necessary for recovery. It is in my life.

The slogan, you do need someone stronger than yourself, my belief in God and a Supreme Being is instrumental in my recovery. My addiction was stronger than me.

I personally could not overcome it without the help of a higher power.

Mr. RANGEL. The committee thanks you and we hope to be working with you, and the Chair will put in the Congressional Record the contribution that you made, and we thank you individually and collectively.

At this point, as the next panel comes forward, we are going to take a break.

[Recess.]

Mr. RANGEL. The Chair would like to acknowledge the presence of Ms. June Fowler, president of the Washington League that is doing a great job.

We have with us for the next panel of cocaine treatment experts, our lead-off witness, Mr. Arnold Washton of the 800-COCAINE Hotline, followed by Dr. Ronald Dougherty of the Benjamin Rush

Psychiatric Center in Syracuse, NY, and the director of the Maryland Department of Mental Hygiene, Richard Hamilton.

TESTIMONY OF ARNOLD WASHTON, M.D., RESEARCH DIRECTOR, NATIONAL COCAINE HELPLINE

Dr. WASHTON. I won't belabor the statistics on the scope of the cocaine problem. They have already been mentioned.

One of the things that struck me as indicative of the change in the problem in the past 2 years alone, when I appeared before this committee in 1983, telling the committee at that time of the very first cocaine hotline that we had set up in New York City, where we had been getting 500 calls a day, just from a local hotline, before we made it national into 800-COCAINE, with people calling us, saying they had a cocaine problem, they knew they were addicted to the drug, but calling treatment centers, and being told that treatment was not available, because the drug was not addictive.

There is no doubt that cocaine is being used by more Americans today than ever before in our Nation's history. The problem has reached epidemic proportions and continues to escalate.

It is America's fastest growing drug problem and one in need of immediate attention and action.

On our 800-COCAINE hotline which can be dialed from anywhere toll free in the United States simply by dialing 1-800 and spelling out the word cocaine, we have now received over 1 million calls from all across the United States in only the first 2 years of the line's operation.

Calls continue to come in at a rate of over 1,200 per day with no tapering off in sight. Government surveys show clearly that over 25 million Americans have already tried cocaine, a staggering number when it is realized that that is 10 percent of the American population.

It is estimated that approximately 6 million people use this drug on a regular basis, meaning at least once a month and more frequently in most cases and there may be as many as 2 or 3 million people seriously addicted to it.

The medical consequences have been skyrocketing, and the problem seems to be spreading like wildfire all across the United States.

Supplies are plentiful, prices have dropped by over 50 percent in the past year alone.

A gram of cocaine is now cheaper than an ounce of marijuana and, therefore, we should not be surprised that in increasing numbers, adolescents, those of lower socio-economic groups are becoming heavily involved.

It is no longer the drug of the wealthy or elite, and it knows no social or economic boundaries and has become the drug of choice of America's middle class and is well on its way to becoming the drug of choice of America's working and lower classes.

Somewhere between 15 and 20 percent of high school students in this country have already tried cocaine and the drug is becoming more popular on college campuses as well.

In addition to the consequences of cocaine use on the individual user, and no doubt as we heard in the previous panel, those consequences are great. It causes a great deal of personal suffering.

We should not lose sight of the fact that this cocaine epidemic has a broader social impact. It saps our economy, corrupts our system of justice, influences our foreign relations with other countries and has even brought death to our own Federal agents' attempt to deal with this problem.

Cocaine in the work place is estimated to cost our economy over $30 billion per year. These are dollars lost in reduced productivity, absenteeism, lateness, more accidents on the job.

Some analysts of the industrial situation in this country, as it relates to the drug abuse problem, have gone so far as to say that at least a segment of the American work force may simply be too stoned to compete with the Japanese and others of our most ardent industrial competitors.

Our country has been beseiged by drug epidemics since the mid-sixties but this one seems to be the worst we have seen yet. I say that for the following reasons.

For the first time we have a powerfully addictive, dangerous drug with widespread appeal to literally millions of Americans who perceive it as benign, harmless and non addictive.

Only a fraction of 1 percent have ever tried heroin, the drug most feared in this country. When fully 10 percent or greater of the American population have already tried cocaine.

For the first time we have so many middle-class employed people trying to do their jobs under the influence of drugs, and this is an unprecedented phenomenon and we have so many of our most successful, accomplished people in this society being seduced into addiction and ruination of promising careers.

It is a deceiver, seducer and a poison to our American way of life and basic human values.

Cocaine and other drug abuse problems are now the leading health problem in this country, and there can be no question about that, affecting more people than cancer and heart disease combined. Yet it remains largely an underground problem, with scarcity of good treatment programs and with social stigma still being associated with seeking help for this problem.

Two aspects of cocaine more than any other have promoted its widespread use and appeal among the American public. The myth that cocaine is nonaddictive and harmless, and the other, and this is the most destructive myth about cocaine, is that if you just snort it—and I underscore the word "just"—that is the way it is reported to us by patients, if you just snort it, you won't become addicted, won't suffer toxic consequences, you won't die from cocaine.

All three of those are absolutely false, based on recent experience. The facts about cocaine are that it is a powerful, addictive drug. Users cannot limit their use, can't refuse it when it is offered and seem to prefer cocaine to food, sex, recreational activities.

Taking cocaine stimulates the desire to take more cocaine, and thus it is a drug that feeds on itself and promotes its own use. One, the cocaine high is so brief and short lived, lasting 20 to 30 minutes on the outside and the second is as soon as the euphoria wears off, it is replaced by an unpleasant type reaction, known as the "co-

caine crash." To stay high you have got to take it at least once every half hour, and to ward off the unpleasant effects that soon follow, you have to repeatedly dose yourself.

Withdrawal symptoms are clearly evident, most evident in high dose users. Tolerance developers to cocaine effects. Animal experiments demonstrate the addictive power of cocaine most dramatically.

If you give animals free access to cocaine, within a 30-day period over 95 percent of them will induce in themselves such massive doses that they die from brain seizures within 30 days and overdose reactions.

Monkeys will reliably choose to press a bar that gives them a high dose of cocaine for which they pay a price, a painful electric shock that immediately follows this high dose. They will choose it over pressing another bar in their cage for a low dose of cocaine with no electric shock.

Hungry, starving animals will choose cocaine over food and die of starvation.

Although not everyone who tries cocaine becomes addicted or suffers medical consequences, this does not mean that even an occasional cocaine use is safe and we talk about prevention. This is really the issue that we must address if we are going to have any credibility at all in our prevention efforts.

What is wrong with occasional use anyway, people ask. Most people don't consider themselves to be candidates for personal addiction. Their personal experience tells them they can snort a bit, and not become a desperate addict.

No addictive personality has been identified for cocaine or any other mood-altering drug including alcohol, and if there is anything that is disturbing about this epidemic, many reasonably mature, stable, well-functioning people who have good jobs, good family support systems become full-blown addicts.

They all started with occasional use, never intended to become addicts, and none even considered themselves to be potential candidates for addiction.

I think we must conclude that experimenting with cocaine is like playing Russian roulette with your health, your life, and your career.

Intranasal use of cocaine offers no guarantee of safety or protection is evidenced by the fact that the majority of callers to our hotline are intranasal users, and the majority showing up at treatment centers are people snorting cocaine, not necessarily free basing.

It promotes the use and abuse of other drugs that are taken in order to offset the unpleasant side effects of chronic cocaine use so the typical cocaine user is forced to become a polydrug abuser. They are dually addicted to alcohol and cocaine because the cocaine user is left only with the unpleasant jittery stimulant effects of the cocaine, but no longer high on the drug and they seek to get rid of that by drinking large quantities of alcohol, taking sleeping pills, tranquilizers, or even heroin so more and more cocaine abusers are becoming polydrug dependent.

The findings from our hotline—and we have compared them from 1983 to 1985, first slide. They show a number of shifts of patterns of use.

The cocaine epidemic has clearly spread to all parts of this country, no longer just a New York or east coast and California, west coast phenomenon.

Surveys in 1983, random samples of 500 callers to 800-COCAINE, much smaller proportions from the Midwest and South were represented in 1983 as compared to 1985 so no doubt that cocaine is available everywhere in this country and being used by people in every region.

We get calls even from small towns in areas of Wyoming, Montana, Mississippi, and Alaska, places you probably thought to be free of cocaine. Another finding is that the number of women involved with cocaine has increased significantly as prices have dropped, and the drug has become more available.

Women represented only about a third of all callers to the hotline back in 1983 and now represent nearly a half in 1985.

Adolescents represent only 1 percent of callers and it was rare to get a call on the hotline back in 1983, that has now increased to 7 percent calling the hotline.

More minority groups are involved with cocaine, no longer just the drug of the white middle or upper class. Blacks and Hispanics accounted for only 15 percent of callers in 1983 and now account for 40 percent of callers in 1985.

As I said before, increasingly cocaine is used together with other drugs that are taken not to get high but to medicate away the cocaine side effects. Sixty-eight percent reported combined use of cocaine and other drugs in 1983, that has gone up to 87 percent in 1985.

The medical consequences of cocaine range all the way from severe sleep problems, chronic fatigue, cough and sore throat and those who are free basing from inhaling the hot cocaine vapors and 14 percent of the callers say they have already had at least one cocaine induced brain seizure, and when cocaine does produce a fatal reaction, it often takes the form of a brain seizure followed by respiratory or cardiac arrest.

Psychiatric consequences of cocaine also span a wide range, all the way from unrelenting depression, irritability, difficulty concentrating down to loss of sex drive, panic attacks, and 9 percent of the callers say they already had at least one cocaine-related suicide attempt that they attribute to the chronic unrelenting and more severe depression resulting from the use of the drug.

Social consequences span a wide range from fighting and violent arguments. It undoubtedly contributes to domestic violence. Many of these middle-class cocaine users with good jobs report they are dealing cocaine to offset the cost of their own habit, stealing often from work, family, or friends. Eleven percent report a cocaine-related auto accident.

This is an important finding, because it tells us something about the interaction between cocaine and alcohol. Somebody high on cocaine because it is a powerful stimulant can consume a large quantity of alcohol and not feel too drunk to drive, not at the beginning.

They get behind the wheel of a car and the cocaine stimulant effects wear off within a half hour and the alcohol effects come in full force, and they may fall into a stupor while going down the highway.

We have asked "have you used it on the job." Seventy-five percent report yes, and they list which drugs they use, cocaine No. 1, followed only by alcohol and marijuana. They report drug-related job problems ranging from reduced performance, dealing drugs to coworkers, stealing from coworkers, and a quarter of the sample said they already had been fired from a job from a drug-related problem.

Cocaine use is associated with glamorous paraphernalia to market the drugs to business executives, and I show you here a gadget that is readily available in New York in candy stores and other places around the city, a Dristan inhaler with the trademark of Whitehall Laboratories on it.

It is a little different. It has a screw-off bottom so you can fill up the inhaler with cocaine powder, and you are fixing yourself with cocaine right there in the board room. Everybody thinks you have a cold.

Lastly, it is important to emphasize that cocaine is a treatable problem. Success rates in motivated patients are good. The treatment must focus on complete abstinence from cocaine, but all mood-altering chemicals and treatment cannot be effective while the person continues to use drugs.

Most can be treated as outpatients and do not need hospitalization. My recommendations are as follows;

One, and I already heard comments this morning from yourself and others, Mr. Chairman, that this is already being done to some extent, and that is public education and media campaigns about drug abuse and drug abuse prevention. We have not yet even begun to tap the power of the media in this country as an educational tool. We must change public attitudes about drugs, decrease their social acceptance and decrease the social stigma associated with getting help.

I would recommend, for example, that some type of joint advisory council be formed because drug abuse professionals, people in Government and those in the public relations and advertising industries to get the message out to change attitudes.

Second, I am strongly in favor of school base-prevention programs and we have a proven, effective model for that, and that is the student assistance model pioneered in Westchester County, modelled after the concept of the employee assistance program but in this case the helping counsellors work in the schools, not in a corporate setting, for early identification of substance-involved youth and prevention programs.

I will emphasize that we must have mandatory drug testing for DWI incidents. People stopped for suspected driving while intoxicated, can pass a breathalizer test for alcohol with flying colors and still be too stoned to drive safely because of their drug use.

I am not aware of a single State that has mandatory drug urine testing in this country.

[The statement of Dr. Washton appears on p. 85.]

Mr. RANGEL. Can we have the lights?

We will hear from Dr. Dougherty from the Benjamin Rush Psychiatric Center in Syracuse.

TESTIMONY OF RONALD DOUGHERTY, M.D., BENJAMIN RUSH PSYCHIATRIC CENTER, SYRACUSE, NY

Dr. DOUGHERTY. Thank you very much for the invitation to come back the second time around.

Cocaine is not a new drug. Erlen Meyer said cocaine is indeed the third scourge of mankind, 100 years ago.

My oldest cocaine abuser was an 81-year-old lady, dependent on cocaine eyedrops.

The symptoms that I see as a treating physician who treats cocaine abuses 7 days a week are blackouts and memory loss to the extent that persons can actually kill while under the influence of cocaine and never remember the event. An individual was hanging his 2½-year-old child out of a third story window, and could not remember.

A cocaine abuser, a caterer, went home after doing cocaine, had raped his 8-month pregnant wife, and put her in premature labor hemorrhaging and would not remember the event. As the alcoholic says, I am an alcoholic; the cocaine addict should always believe he will never get away craving.

A 21-year-old individual, during his fifth week in the hospital, said, "May I speak to you?"

I said, "No problem."

He put his back to the door, raised his fist in my face, and said "You SOB. You have been putting mind-altering drugs into my vitamin capsules."

I began to sweat, and like Joan Rivers said, "Can we talk?"

He said, "What has come over me?"

I explained to him that is the craziness of cocaine without being crazy.

Sexual disinterest is common with cocaine abuse. Originally sex and cocaine go together but later not unlike my 29-year-old patient who said, "I have not had intercourse with my wife in 3 years. I prefer to go to bed with my white lady, cocaine."—sexual interest fades.

I had a patient admitted yesterday, doing a thousand dollars' worth of cocaine per day, who has lost 35 pounds in the past 2 weeks. Five out of the first six women admitted to our unit who were doing cocaine also had a problem with anorexia bulimia.

Cocaine is the ideal drug for the person who wants to appear chic, svelte, and you don't have to bother eating.

People who do cocaine are in danger of dying, but so also are people who are body packers. It is not uncommon for body packers to swallow 50 or 60 condoms full of cocaine. They swallow honey or mineral oil first. If they fly in an unpressurized plane, cocaine migrates out, water migrates in and these people have a rupture and die in flight. A young man, a body packer, made it to a local motel in New York. The individual was dead. They found milk of magnesia, mineral oil, et cetera, on his bedstand. He had a plane ticket with him having come from Florida 1 day earlier.

He was autopsied and found to have at the time of autopsy, his GI track full of a number of double-wrapped condoms entirely full of cocaine. He had not had any one of these rupture. It was thought possibly then he had cocaine migrate into his blood stream. He did not. He had taken too much tap water enemas and killed himself from an electrolyte imbalance.

Cocaine can indeed cause a whole array of medical consequences, from headaches to sexual dysfunction, neuropathy, and vitamin deficiencies. Most people out on the street who do cocaine snort it. By the time they come into our program, people are doing from $300 a week up to $1,000 worth a day. There has been a shift from 80 percent down to now 40 percent of abusers snort cocaine and 30 percent free base the drug.

Twenty percent shoot their cocaine, doing it recreationally, and 10 percent use cocaine via all routes of the above. It is absorbed inside the lower lid of the eyes, absorbed in the nose, and I have a physician who is a cocaine addict who swallows his cocaine, because he has ready access to it, we have people who use it vaginally.

I had a 17-year-old cocaine dealer referred to me from the Rochester area. I said, "Do you snort?"

She said, "I don't snort it. It gives me a bloody nose. Free basing makes me short of breath. I take it rectally with an eye dropper."

People use all kinds of imaginative ways of cocaine administration. An individual, went through $20,000 worth of his father's lumber mill business. The third day in the hospital he blew his nose, went to the nurse's station and said, "This kleenex looks different." It was the last third of his nasal septum he had just blown out.

It is a big deal to have a hole in your nose. These are infected, chronically draining, sources of infection going to the brain. Ear, nose, and throat specialists replace the nasal septum with a prosthetic ENT nasal septum button.

These are cocaine burns on an 18-year-old girl. She can't find a vein in her breast. She has to be somewhat of a contortionist to be able to shoot this dope in her legs. She is indeed a victim of an addictive drug.

Free basing is a favorite route of administration now, and I have not found anybody who has gone to free basing able to cross back over the line and go back to snorting.

It takes 8 seconds to get to the brain when you smoke (free-base) cocaine. The 5-minute rush is what people try to achieve, a total orgasmic experience never achieved any other way, and once they go to free basing they will not go back to any other route.

I have people with very serious lung damage—25, 30 years of age, who cough up blood all of the time, have permanent respirator dysfunction, with lack of oxygen, and carbon dioxide exchange.

A young man says of his female companion, "We were doing a few lines of cocaine." She shook all over, got back up, laid down, shook again. Then she didn't get up. This young lady did not have an extremely high blood level of cocaine in her body. She lowered her threshold for convulsions and died. She had a massive grand mal seizure, and it is the most violent kind of seizure we have. She bit all the way down through her lower lip.

A hospital pharmacist obtained all the hospital pharmacy cocaine, had himself a little party. He ended up having a cardiac death because it is a—is a cardiac stimulant.

Cocaine is an equal opportunity drug. It can kill you when you use it by snorting it, smoking it, or shooting it.

Twenty eight percent of our people who come in are abusing cocaine alone. Persons will try to minimize their alcohol involvement, but 40 percent are cross addicted to alcohol.

Patients will say, "I don't have a problem with marijuana." "How much do you do?" "A quarter ounce of marijuana per day." Patients only consider the drug which causes them the most problem as the "king" drug.

Women may often be doing alcohol at the same time that they abuse coke. A baby born to a mother who did cocaine during the first 4 months of her pregnancy and stopped. The baby did not have any cocaine withdrawal or fetal alcohol syndrome.

Another youngster was born to a mother heavily using cocaine and she also continued to use alcohol. The baby had motor and mental retardation. He was named "Kookene" by the mother.

Of those cocaine abusers who come in 85 percent are males, and 15 percent are females. The interesting thing is that 40 percent of people who call in are women, but only 15 percent are admitted. There still is a double standard out there in that the women should stay home, be the gatekeeper, take care of the kids, the dog or the cat, and don't come in for treatment.

The women who do come in are using far more cocaine than males, and have much more serious problems. Eighty percent of the men will not support their mate, but the reverse is true for women; 80 percent of them will stand by—support—their mate's recovery.

We have gone from 5 percent of our admissions being black last September to 25 percent of our admissions now being black. There are other serious consequences of cocaine. At least 30 percent of our patients say they are stealing from their family, stealing furniture, come in late for work, have problems with job performance.

Ten percent of the patients are under the serious influence of cocaine while driving. I had a young man, a farmer, from upstate New York who borrowed $40,000 from a Federal agency, put $20,000 into his vein, drove his car down the road, sideswiped a tree because he was impaired. He was surprised and happy because the only thing missing from the car was a sideview mirror. He went home, walked into the house, and his girlfriend said, "Where is your left arm?"

He had left his left arm back at the tree.

We find more and more people who are driving erratically, who when stopped, their alcohol content is very low; but if we had an ability to mark how much cocaine was present, they would be ticketed for being impaired.

By Fortune 500 standards, cocaine is now the eighth largest industry, between Standard Oil of Indiana and Du Pont. The marijuana industry, 15 percent which comes from Marin County, CA, is only an $18 billion industry.

We must stop cocaine. But unless the legislators and the judges help us, we will lose this battle.

We have a judge in New York City who we call "Turn 'em loose" Bruce. He set bail at $200,000 each for 22 cocaine dealers, and they took that out of their pockets in change; and they were on the next plane back to Bogota.

Cocaine is not just a big city problem. We have uncovered two cocaine basing factories in central New York; one is 100 miles east of Syracuse and one, 60 miles.

One cocaine basing factory yielded 700 million dollars' worth of cocaine. Will we stop it? It is not only going to involve us in rehabilitation, but you people in Washington are going to have to help us.

We were intimidated a month ago by those people who held 39 of our people hostage in Lebanon. We are being held hostage by three countries that supply 95 percent of the cocaine of the entire world and over 50 States, and we have to impose some kind of sanctions, whether it be military or economic, before we are going to stop this epidemic.

We cannot stop marijuana because it grows so readily in this country. The coca plant does not grow in the United States, or it would be already here. There is one way to stop this. Get a message across. We are mad as hell, and we are not going to take it anymore.

It involves a serious commitment on the part of rehabilitation, law enforcement, and also you from Government.

Thank you very much.

[The statement of Dr. Dougherty appears on p. 96.]

Mr. RANGEL. Thank you, Doctor.

The committee will be going into those countries and enacted recent legislation that will be giving assistance to those countries and we hope get better results.

Mr. Hamilton.

TESTIMONY OF RICHARD HAMILTON, DIRECTOR, DRUG ABUSE ADMINISTRATION, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Mr. HAMILTON. It is an honor and privilege to be here this morning to share with you some of my personal concerns about cocaine and also concerns of the State of Maryland in this very important matter.

Two years ago, even as late as 1 year ago, several of us were making speeches saying that this country was on the threshold of its most destructive epidemic—an epidemic of cocaine abuse. This morning the message has changed. We have crossed over that threshold and are deeply involved in an epidemic that will have serious consequences for this Nation during the next decade. Only new, creative, innovative, well-funded treatment and prevention programs will impact upon the situation; nothing can prevent it from happening and affecting hundreds of thousands of lives.

Several major patterns have developed in the abuse of cocaine that are unique to this drug and yet are affecting the drug culture and enticing many unsuspecting persons into it. One of these is called speedballing or the mixing of cocaine and heroin for an intravenous injection. Heroin is perhaps the best drug to fight the de-

pression always present when one comes down from a "coke run." But speedballing creates not only cocaine addicts. After the cocaine is gone, we have a heroin addict to treat.

A second phenomenon has been the rapid drop in price. In almost every other drug scare the number of people using had little effect on the price. With cocaine, even with the demand skyrocketing, the price has plummeted. In the document provided you, I have cited these costs in various cities in the United States.

Baltimore is a good example of what has happened. In the summer of 1983, one would pay $85 for a capsule of cocaine; today that capsule costs $15. At one time not too long ago, it seemed that only the rich and famous would be affected. It seemed that perhaps the poor were safe but with this kind of price reduction now even the poor can afford to get high, get sick, get addicted to what I believe is the most dangerous drug in our society.

The third and maybe the strangest phenomenon connected with cocaine is that Government for the most part has stayed out of the treatment picture. There are several reasons for this which must be investigated and corrected.

First, the cocaine problem began to be noticed about the same time the Federal Government began a cut back on drug treatment funds through the creation of block grants. The first year funds were reduced about 25 percent.

Since 1981, the drug abuse budget in Maryland has increased from $9 to $12 million. However, this has all come through State increases while Federal dollars continue to decline. Governor Hughes and Adele Wilzack, secretary of the department of health and mental hygiene of Maryland, of which drug abuse is a part, understand the drug abuse problem and consider it a top priority. Many other State drug abuse programs haven't been so fortunate.

At the same time Federal funding was decreasing and the cocaine problem was becoming an epidemic, we in Maryland were right in the midle of a heroin epidemic which forced us to expand our treatment capacity by 50 percent in just 3 years and now is forcing another 30 percent increase in the next 2 years. And yet the question remains, what to do about cocaine?

Cocaine has until very recently been the drug of people with money or at least with insurance so that when treatment was needed it was provided by a private source. Government took the position that public treatment facilities were not needed.

Suddenly, as I said before, cocaine reached a price that made it available to all. We now have large groups of people addicted to cocaine who do not have hospitalization nor other money for treatment and they are beginning to pile up in a publically funded treatment system already overcrowded with 6 to 8 week waiting lists. In Maryland, the average waiting time is 42 days for entrance into treatment.

What is the solution? I have some ideas which I would like to share.

First, you who are statesmen, politicians and foreign affairs advisors should create a new method for developing treaties with the cocaine producing countries of the world. Pay them off, if need be, for the cost of those treaties will be less than the resulting cost to our citizens, physically and emotionally during the next decade.

Second, utilize every means possible including the military to stop the material at our borders and to arrest the international groups responsible for the intercontinental transport of cocaine. It is time we declare an all-out war on the substance.

Third, it is estimated that more than 20 million people in the United States have tried cocaine. In Maryland that estimate based on some pretty accurate data is more than 40,000; 10 percent of our population. We presently have 1,952 in treatment and last year treated over 5,100 patients with cocaine problems and the number is continuing to grow.

No amount of treaty negotiation or enforcement measures will help these people already addicted. They need treatment. Therefore, there should be a special pool of money established especially for the treatment and prevention of cocaine abuse. This money should be granted for hands-on demonstration projects and especially for short-term residential protocols. This funding program should have a minimum life of 3 years.

In closing, I would like to thank you for inviting me here this morning. I have been involved in drug abuse treatment since 1967, and have directed or helped to direct programs in Delaware, Pennsylvania, and for the past 9 years in Maryland.

During that experience nothing has frightened me about the future as much as this present cocaine epidemic. I plead with you to be alert to it, to its consequences and use this committee to impact upon its control.

Thank you, Mr. Chairman.

[The statement of Mr. Hamilton appears on p. 102.]

Mr. RANGEL. Thank you. And this is unusual for me to ask you to respond to a statement which has been submitted by the Acting Assistant for Health and Human Services, James Mason, who will be following this panel.

In reviewing his testimony, one of the statements that he makes is that, and I quote:

> Our most recent surveys indicate that the number of new cocaine users has begun to level off, at least among those under 26, and young people are reporting increased awareness of the negative consequences associated with the drug.

Does that make any sense in terms of the experiences that you have had?

Dr. DOUGHERTY. Not at all. We applied to the Department of Mental Health in New York State to add on 60 more beds, 30 for adult and 30 for adolescent abusers. There is no decrease, but an increase in use because of the improved quality, decrease in price.

Mr. WASHTON. Our hotline experience shows 1,200 calls a day on average with no tapering off in sight. Our treatment facilities have waiting lists as do those of other areas known to us across the country.

Mr. HAMILTON. I believe that is watered down because of the nature of the national statistics that NIDA and the others tend to quote. The same thing happened in 1980 when the Northeast part of the United States found itself engulfed in a heroin epidemic out of Afghanistan, Pakistan, and Iran. The national figures showed no increase and yet in the northeastern part of the United States we were experiencing substantial increases to the point where we fi-

nally had to prove to NIDA that it was happening and they put $3 million additional in heroin treatment. We don't see that kind of interest in the cocaine epidemic.

Mr. RANGEL. The administration has publicly declared war against narcotics. Have you felt the impact of that war yet?

Mr. DOUGHERTY. Not as yet. Our regional attorney general did receive a mandate from the Reagan administration to start coordinating their efforts with those in the field. This is probably as a result of finding so many cocaine factories in the upper New York State area.

Thank God, high school students appear to be using less drugs. They are being done with seniors in high school. Forty percent of whites, 60 percent of blacks, 90 percent of Chicanos drop out of school and mainly because of drugs.

Mr. WASHTON. Mr. Chairman, the other side of that argument, though, it is important to recognize that there is some degree of substantial time lag between the data that you mention and what we see in a treatment facility. Even if we assume at present that the cocaine epidemic has leveled off and new users are not being inducted into the phenomenon at a greater rate, we would expect to see more people seeking treatment because those that started using the drug several years ago currently are getting into difficulty with the drug and asking for help.

I don't think the data and our observations are necessarily contradictory. Let's hope that they are encouraging us in telling us what we might see 2 or 4 years from now. Our estimate is that the epidemic is probably not going to peak for another 3 to 5 years.

Mr. HAMILTON. The only place that the war on drugs has seemed to affect a State level has been an increase in prevention, in the thrust of prevention. With the 20 percent set aside on the block grants, it has forced many States to develop prevention programs that were not inclined to do so before, so we are seeing more prevention material and the amount of prevention coming out of the Federal Government is more and is better.

As far as decreasing, and I go along with what Dr. Washton said, we estimate a 3-year timelag between the onset of drug use and the seeking of treatment.

Mr. RANGEL. Mr. Coughlin.

Mr. COUGHLIN. Thank you, Mr. Chairman.

We certainly appreciate your very shocking and sobering testimony.

How do we more effectively communicate the dangers of cocaine and what should we be doing that we are not doing? How do you go about it?

Dr. WASHTON. There is no—certainly we all recognize there is no simple solution to this problem. I don't think any single prevention program or public education campaign by itself will do it but something said in the last panel deserves repeating, and that is, I think we have to change our attitudes in this society about drugs to the extent that being drug-free comes to be seen as one of the necessary ingredients to be a successful person in this country.

The message has been exactly the opposite up to this point, that you can be a successful person despite being drug dependent, and

you can be successful although you may end up as an addict, perhaps not, but it is attitude change more than anything.

I think that we are making some headway in that regard. I do see some attitudes changing. Certainly there is an emphasis in this country on getting straight, if you have a drug problem. Treatment programs would not be proliferating as they are, if that were not happening. We need to do more but we have started to make some headway on that.

Using the media, that is a way of communicating a societal value, and this is the bottom line.

Dr. DOUGHERTY. I would agree.

The youngest cocaine abuser we had referred to us was a 11-year-old girl. If we educate kids as we did about smoking—I have seen more adults quit smoking because of the harassment from the young kids, all these other substances are always dangerous, not just the cigarette—we will have gone a long way.

The Drug Enforcement Administration, they had somewhere 2,800 DEA agents to patrol our five coastal states, they should triple that. This is an all-out war, let's get serious about it.

Mr. HAMILTON. I agree with what the other panelists said. The only difference I might have is it seems to me at times we try to use the shotgun approach, when we should use the rifle approach. My 25 years in the business, I have never been as frightened of anything as I am of cocaine and rather than the talk in general, generalization about drug abuse, and although I think it is a way of life and it must be attacked, the time has come when we ought to zero in on the cocaine problem and deal with that problem at all age levels to make sure that that problem is attacked, and we do something about that.

If we deal with cocaine, we can deal with a lot of other problems.

Mr. COUGHLIN. Doctor, you cited the number of school dropouts. Do you have any figures as to the number of school dropouts that are drug users?

Dr. DOUGHERTY. In our treatment program, the majority of kids referred to another program in Syracuse, Alpha House, the majority of those kids come in because of legal problems that they have related to drugs, 8 out of 10 have been dropouts. If you trace their history, there was a progression of alcohol, marijuana, then harder drugs and 8 out of 10 dropped out of school because of drugs.

Eight out of every ten of our kids in our adolescent programs drop out of school because of drugs.

Mr. COUGHLIN. As in DWI kind of programs, is there any test that is immediately identifiable for a cocaine abuser, cocaine being in the body?

Dr. DOUGHERTY. A urine test called EMIT, Enzyme Multiplied Immunology Assay Technology, qualitative test. The problem is, a lot of attorneys will find fault and say my client is not going to unzip his whatever at 20 degrees below weather and give a specimen.

There is going to be a continued fight especially with the attorneys. To say that this fellow was driving while impaired, we instructed him to be driven to the closest emergency room and subject him to drug screening.

Most will not show positive for cocaine past 48 hours, and I have gotten fooled on that.

Physicians, cocaine addicts, 48 hours before they come in, they would avoid doing it. So you must get it fairly soon after you suspect it.

Mr. RANGEL. Thank you. The committee intends to work individually with you and with your groups.

We will recess for 5 minutes. And then the committee will conclude with the last panel.

[Recess.]

Mr. RANGEL. The Chair appreciates the patience shown as we conclude these hearings, and I apologize to this panel but it is clear that we have gone beyond our time. James Mason, Acting Assistant for Health and Human Services, and he has with him Dr. McDonald, and Dr. Marvin Snyder from the NIDA.

Mr. Mason.

STATEMENTS OF JAMES O. MASON, M.D., ACTING ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES; IAN MACDONALD, M.D., ADMINISTRATOR, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION; AND MARVIN SNYDER, Ph.D., DIRECTOR, PRECLINICAL RESEARCH, NATIONAL INSTITUTE ON DRUG ABUSE

Dr. MASON. Thank you, Mr. Chairman. We are very appreciative of this opportunity to discuss the consequences of cocaine use and the steps that we are taking at the Department of Health and Human Services to deal with what we consider to be a major public health problem.

I am delighted to have Dr. Macdonald, the Administrator of ADAMHA, and Dr. Marvin Snyder, National Institute on Drug Abuse, here with me.

I have testimony to be submitted for the record with numerous tables and history.

Mr. RANGEL. Without objection.

Dr. MASON. I would like to begin by providing a historical perspective.

The use of cocaine is not new. Its use was widespread in the late 19th and early 20th centuries when it was an ingredient in many patent medicines, tonics, and soft drinks. Between the 1930's and the late 1960's, cocaine all but disappeared from the American scene. This downturn in cocaine use was probably due to a number of factors, including the Depression and restrictions on the importation, manufacture and distribution of cocaine.

As recently as the early 1970's, cocaine use was not a major problem. In 1973, the second report from the National Commission on Marijuana and Drug Abuse stated that, on the basis of available data, they could verify little social cost related to cocaine use in this country.

Unfortunately, these low rates of actual abuse may have led the public to conclude that cocaine was a safe drug. On the other hand, many drug experts and a number of Government publications were stating—for those who wanted to listen—that cocaine use could have serious negative consequences and that under conditions of

greater accessibility much more serious patterns of cocaine abuse would become evident.

The introduction to cocaine: 1977, a monograph produced by the National Institute on Drug Abuse expressed a similar view. It stated that "if cocaine becomes cheaper and more readily available, dosages will undoubtedly rise and the more unpleasant and dangerous aspects of the drug may become more apparent."

Such warnings have indeed proved prophetic. In the last 15 years cocaine abuse has grown from a relatively minor problem to a major public health threat in the United States.

Our most recent surveys indicate that the number of new cocaine users has begun to level off, at least among those under 26, and young people are reporting increased awareness of the negative consequences associated with the drug. Nevertheless, we are definitely seeing the impact of the dramatic increases in cocaine use in the late 1970s and of heavier use among certain subgroups of cocaine users in the greatly increased demand for treatment of dependence and the number of medical emergencies associated with cocaine use.

Our statistical data give us some idea of the overall dimensions of the cocaine problem. For we know from the national household survey, which is conducted periodically by NIDA, that the number of people trying cocaine at least once—lifetime prevalence—increased from 5.4 million in 1974 to 21.6 million in 1982.

The number of current users—which we define as any use of cocaine in the past 30 days—of cocaine increased from 1.6 million in 1977 to 4.3 million in 1979 and remained stable at about 4.2 million in 1982. I should note that the 1985 Household Survey, which includes additional questions on cocaine use, is now in the field. Data from that survey will be available shortly after the first of the year.

Today cocaine use is distributed throughout our population. While cocaine use appears to be higher among those with at least a high school diploma or those who are employed, it should be noted that use is found in all income groups. Lifetime prevalence for adults reflects the male predominance in illicit drug use that has been the pattern in our society. Among youth, ages 12 to 17, lifetime prevalence rates for males and females are almost equal.

It seems that today some people view cocaine use as if it were a separate drug using phenomenon. On the contrary, people who use cocaine have already experienced the use of other drugs, especially marijuana—98 percent of people who have tried cocaine in their lifetime have also used marijuana and at least 93 percent of those used marijuana first.

Nearly three-fourths of those who have used marijuana 100 or more times have tried cocaine. A similar pattern was found in the high school senior survey, where 84 percent of the current cocaine users are also current marijuana users. In addition, 80 percent of the high school seniors who have used cocaine in the past month report having five or more drinks on at least one occasion in the 2 weeks prior to interview, and 50 percent smoke cigarettes daily.

Adverse health effects of cocaine use do not always occur with the first use of the drug. Consequently, it is necessary to contrast the trends in use of cocaine with the trends in medical emergencies

and demand for treatment. It is not at all surprising that even though the most recent surveys of prevalence of use indicate that the number of new cocaine users has leveled off—at least among those under 26—the impact of the dramatic increases in cocaine use in the late 1970's is becoming more and more visible in terms of demand for treatment of dependence and medical crises associated with cocaine use.

This data on admissions to drug abuse treatment are collected on a voluntary basis and currently there are approximately 15 States that report these data to NIDA.

This data indicates that emergency room admissions associated with cocaine use increased approximately 3.5 times between 1976 and 1981. More recent data, based on a subset of emergency rooms that have consistently reported to DAWN since 1981, indicate that this upward trend continues unabated. There has been a particularly dramatic rise in cocaine mentions from emergency rooms since the first quarter of 1983.

Recently NIDA initiated a special study of cocaine trends using a 9-year panel of consistently reporting hospitals from DAWN. The data reflect almost an eight fold increase in the rate of emergency room visits for cocaine-related problems per 1,000 emergency visits. While the increase in rate has been greater for hospitals located in the central cities, parallel increases have also been seen in hospitals located in areas surrounding the center city. Recent top 10 city rankings are noted in table 6.

There has been a slight increase in the percentage of females reporting to emergency rooms for cocaine problems—from 31 percent in 1975–76 to 34 percent in 1983–84. An aging of the population of cocaine users has also been noted.

In 1975–76, 25 percent of the individuals involved in cocaine episodes were 30 years or older, while in 1983–84, 41 percent were 30 years or older. Generally, females using cocaine tend to be younger than males. Forty-five percent of males involved in cocaine abuse episodes were over the age of 30 versus approximately one-third of the females.

As has been mentioned previously cocaine users often use other drugs. In more than two-thirds of the cocaine-related emergency room episodes there has been an implication of other drugs used in combination with cocaine.

Increases have also been noted for admissions to publicly funded drug treament programs. Our data indicate that in 1983, primary cocaine problems accounted for 7.3 percent of all admissions and secondary cocaine problems for 10.5 percent.

For the first 6 months of 1984, however, primary cocaine problems represented 13.9 percent of all admissions, and secondary cocaine problems represented an additional 14.8 percent of admissions. Thus, more than one-fourth of the treatment clients now reported to NIDA have a problem with cocaine use.

While snorting or inhalation continues to be the predominant mode of administration, representing 57 percent of recent treatment admission, freebasing or smoking of cocaine increased substantially from less than 1 percent in 1977 to 4.7 percent in 1981 and is now reported as the mode of administration by 16 percent of

primary cocaine clients. Injection as a route of administration was involved in almost 25 percent of the cocaine related admissions.

In summary, epidemic increases in the incidence of cocaine use occurred in the country in the mid to late 1970's. Although 1982 survey data provide some evidence of new use among the population aged 26 and older, there is no evidence of significantly increased levels of new use of cocaine in the general population.

Mr. RANGEL. Doctor, I am sorry to interrupt your testimony but Congressman Coughlin and I are going to have to respond to these bells, and we will resume the hearing in 10 minutes—recess for 10 minutes and resume the hearing.

I would want all of you to know that my questioning, when you finish your testimony, will center around, now that we know what the problem is, what are we doing about it in terms of prevention, education, rehabilitation, the Federal Government doing about it.

Thank you very much.

[Recess.]

Mr. RANGEL. Doctor, I am sorry for the interruption. You may proceed.

Dr. MASON. Thank you very much.

Just a word about the adverse effects of cocaine use. We agree with the witnesses that have preceded us.

Despite the fact that increasing numbers of individuals are entering treatment for problems associated with cocaine use, there still appears to be a pervasive belief in our society that cocaine is not an addictive drug. This belief may have arisen because of the tendency to equate a drug's addictive potential with the occurrence of dramatic physical and physiological withdrawal symptoms when its use is discontinued. The evidence as to whether or not discontinuing cocaine use precipitates physical or physiological withdrawal symptoms in all individuals appears to be inconclusive. Further, the manifestations of withdrawal from cocaine are more like signs and symptoms of depression than the more obvious distress seen after withdrawal of opiods or sedatives.

However, let me emphasize that there is absolutely no question that cocaine is one of the most powerfully addictive drugs known, exerting its effect by acting directly on the reward or pleasure centers of the brain. This action produces an intense desire to experience the effects of cocaine again and accounts for the development of compulsive use beyond the control of the user. In fact, the strength of the reinforcing properties of cocaine are greater than those of heroin, and in that sense, it is more addictive.

Increased doses of cocaine also place the user at high risk for acute toxic reactions, including cocaine induced seizure and convulsions, respiratory function disturbances, cardiac arrythmia, and myocardial infarction. Cocaine overdose can result in coma, and death from respiratory or cardiac arrest.

I will now discuss NIDA's role in cocaine research.

It should be clear that the department regards cocaine as a significant public health problem, both in terms of the number of users and the serious adverse consequences for which these users are at risk. In addition to our continuing efforts to track trends in cocaine use and to refine our data sources to get an even more accurate picture of the dimensions of the problem, the National Insti-

tute of Drug Abuse is devoting an increasing proportion of its resources to research aimed at understanding exactly how cocaine works, what its effects are, and what treatment prevention approaches are most efficacious in dealing with this particular drug. In 1984, for example, the Institute funded approximately 23 grants related to cocaine and other stimulants.

Last year, NIDA published "Cocaine: Pharmacology, Effects and Treatment of Abuse." The monograph discusses the scientific evidence that cocaine is powerfully addictive and describes how it activates reward circuits in the brain. It also discusses current and experimental treatment for cocaine abuse. In July of 1984, NIDA held a national symposium on cocaine for the purpose of developing a comprehensive description of patterns and consequences of cocaine use in this country. Prominent clinicians, researchers, and epidemiologists presented papers now being prepared for publication in another monograph entitled "Cocaine Use In America: Epidemiologic and Clinic Perspectives," which is expected to be released in early fall, 1985.

NIDA has also been working in close collaboration with the World Health Organization in order to develop a global strategy to combat cocaine abuse.

Research into the treatment of cocaine abuse has also become an important priority area of this department. The apparent heterogeneity of cocaine users, in terms of demographic, socioeconomic, cultural, an environmental characteristics, combined with differing drug use patterns and combinations, suggests a number of different treatment settings and approaches may be required to deal with the cocaine problem. There is not—and will not be—a magic bullet for curing cocaine dependence, and clinicians will continue to need to match the therapy to the individual client. Nevertheless, we have learned a good deal about several approaches which seem to work for many individuals. These include psychotherapy, behavior modification, self help strategies, and various pharmacotherapies.

As important as we consider our research on cocaine treatment, it is equally important that we disseminate the results of that research to the practitioners who can make use of them.

In addition to the monographs mentioned above and other publications produced by the Institute, NIDA has developed a number of other mechanisms for disseminating knowledge to the field. During the past year, there have been a series of symposia—in Portland, Boston, Atlanta, Los Angeles, New York, Dallas, and Chicago—designed to disseminate research-based treatment knowledge to practitioners.

Finally, I would like to summarize our current activities in another area which I believe holds promise for solving our cocaine problem—prevention. Since our data very clearly indicate that cocaine use is not a phenomenon separate from other drug use, all of our activities in the area of primary drug abuse prevention—whether they are focused on cigarettes, alcohol, or marijuana—can be expected to have an effect upon cocaine as well.

At the same time, we are developing other activities specifically aimed at the prevention of cocaine use. Last November, NIDA convened a cocaine prevention discussion group, made up of experts in the field. They felt that there was a pressing need for the dissemi-

nation of new research and epidemiological information in understandable language, to all segments of the general public. NIDA is developing a resource package to provide to individuals and groups interested in becoming involved in cocaine prevention activities.

Another activity is a nationwide media campaign, planned to begin in January 1986. Early last month, NIDA signed a contract with the advertising council for this campaign which is designed to increase and maintain the public's attention to the health and psychological consequences of cocaine use. The campaign's primary audience will be young adults, 18 to 35 years old, including those working and in college. We want to encourage and support the ability of young people and other potential users to resist the pressure to use cocaine. Families, friends, employers, and coworkers will be secondary target audiences.

We have learned that young people respond best to serious, authoritative information, and we intend to use messages that deal directly and specifically with the known health consequences of cocaine. Needham, Harper Worldwide, the volunteer ad agency that designed NIDA's recent "Just Say No" prevention campaign, will also work with the Ad Council on this project.

In addition to television and radio spots, the campaign will include print ads and articles in newspapers and magazines, transit ads, information bulletins and factsheets, posters, and other collateral materials, and exhibits at meetings and conferences. We believe that the campaign will be successful in increasing awareness of cocaine as a dangerous dependence producing drug and in changing societal attitudes toward it. It is our hope that these changes in turn will affect a downturn in cocaine use.

We at the Department of Health and Human Services are extremely concerned about the threat cocaine use represents to our citizens. In order to deal with the greatly increased numbers of negative health consequences and the special treatment needs manifested by cocaine users, we are devoting—and will continue to devote—considerable resources to research, including treatment research, and prevention activities focusing on cocaine use.

This hearing itself will focus a great deal of national attention on the dangers of cocaine use. I am grateful for the opportunity to testify today and will be happy to answer any questions you may have.

[The statement of Dr. Mason appears on p. 118.]

Mr. RANGEL. Thank you, Dr. Mason, and thank you for your patience.

I guess all of the witnesses have agreed that we have to fight this war on many different fronts, and certainly with the source countries—that is, the supply—we obviously are losing that war, no matter what statistical data we rely on, whether it is our own State Department or the United Nations, and notwithstanding our efforts, lack of efforts, we expect bumper crops in each and every one of the drug producing countries.

We have to strike effectively in law enforcement and here the Federal Government has increased its effort there but decreased assistance that is given to local law enforcement and as long as we find our courts and jails swollen with crimes related to drug abuse, we are losing that war. So naturally a lot of people believe that the

best area that we have to conduct an effective front would be in prevention and education, and I assume that if we had to pick an agency, it would be your agency, your department, to see what we are doing there.

Yet, in listening and reviewing the testimony that we received today, I get the impression, and hope that you would correct me, that we are holding a lot of meetings, we are having a lot of symposia, we have got some publications going for us, that we have entered into a contract with the ad agency and got a pretty effective campaign going on, but that is the extent.

We are doing some research to find out just how bad the problem is, but Dr. Mason, our President has declared a war. Is there any presence of the Federal Government on the local level in our schools, in our communities, is there a Federal program, a model that the local and State people can say this is where our government is, this is where we are in treatment? This is where we are in rehabilitation, and this is where we are in education, and prevention?

Dr. MASON. If I may, I will call upon Dr. MacDonald to summarize what ADAMHA is doing.

Mr. RANGEL. Very good.

Dr. MACDONALD. We have seen some positive signs in this very negative business of increased numbers of people dying, increased emergency room visits and increased admissions to treatment programs for cocaine abuse. The positive side in the high school survey previously commented on, reveal an increased awareness in this last year of the number of high school students who perceive the dangers of cocaine.

Mr. RANGEL. I probably did not word my question carefully because you are good on surveys and I am not going to argue with your statistical data, and I know we are turning the corner and there are good signs that we are seeing.

All I want to know is that as part of the Government, if we have declared war, where is your agency, and what role are you playing in terms of educating our youngsters, preventing drug abuse, treatment and rehabilitation?

Dr. MACDONALD. Let me deal with the first business of education. What I was talking about was we do think young people are better educated now in the dangers of drugs than they were a few years ago.

Mr. RANGEL. As a result of a Federal effort?

Dr. MACDONALD. I think that the National Parents Movement supported by the administration with information from the National Institute on Drug Abuse, has been an important factor in community involvement. Our relationship with——

Mr. RANGEL. That is a volunteer group?

Dr. MACDONALD. That is a volunteer group.

Mr. RANGEL. You probably know that I come from an area that is pretty hard hit with drug abuse.

Dr. MACDONALD. Yes sir.

Mr. RANGEL. I assume you would be among the first to admit, that this National Parents type group is not very effective in my type of community?

Dr. MACDONALD. No, sir; I would not. Although the history has not been very good, I recently visited the inner city of Oakland, CA, which is a largely black community, I was most impressed with the results of an inner city movement led by John Brant and with money from——

Mr. RANGEL. I hope you are not confusing me with the Congressman from Oakland.

Dr. MACDONALD. I am not. My response is intended to show that the parents movement can be effective in a community where the community has previously not been involved.

Mr. RANGEL. Doctor, you have gone 3,000 miles to a different type of community. The fact that the residents may be black does not prevent the problem that I have in Harlem, and Bedford-Styvesant and the problem that exists in Chicago and our committee has gone to these cities and we are on the way to Oakland but if you can bring it a little closer to the cities that we have visited, are you telling me that a national effort is supportive of volunteer groups that work with these kids?

Dr. MACDONALD. That is part of the effort.

Mr. RANGEL. OK.

Dr. MACDONALD. In the Oakland community there was a meeting of a network of minorities with representatives from all over the country who were buying into the Oakland model and taking it home. That is only last October or November that that happened, but we are hopeful that we will see results from that.

Mr. RANGEL. If you are telling me that this war has been on for 5 years, we are depending on a voluntary group, that the model is set in Oakland and that you invited people to review what we are doing there with the volunteers, that is not very hopeful. We have had 5 years gearing up for this war. Is this where we are ending?

Dr. MACDONALD. No, sir; I am mentioning that as a very productive start, which is utilizing families and communities.

Mr. RANGEL. We have got the comic books out, too, and the First Lady doing television. What are you proudest about—the same question I asked of Dr. Mason—in this war, in the area of prevention, education, treatment, rehabilitation? In other words, in the area of demand, what are we doing, Doctor, and how can we improve upon it?

Dr. MACDONALD. I am not sure of all the answers to how we can improve on it. We have a long way to go. I am happy with the fact that the numbers we are looking at seem to be better. I am happy with the marijuana numbers this year and that does relate to the cocaine issue.

Mr. RANGEL. It is either me or you, Doctor, but you keep telling me about the numbers that you are happy with and as far as I am concerned, that deals with research and a compilation of statistical data. It could be a bad crop in South America that would give you those numbers.

Now, we are trying to handle, with the State Department, the foreign countries, DEA, and Justice, the law enforcement part. The only reason that you have been invited here today was to report on that part of this war that deals with what we are doing to prevent our kids from becoming drug abusers. I notice you are satisfied

with the way the results are coming in, they are turning the corner and things are looking up, and I have read all of that.

All I want to know is, do we have a program? Is there a Federal program that any State education commissioner could say these are the Federal guidelines that we have to use if we are going to prevent our youngsters from becoming drug abusers? Is there a book that we are saying this is what the Federal Government is doing, we have researched it, this is what we think will work? Do we have that?

Dr. MACDONALD. There is a book called "Parents, Peers and Pot," printed by NIDA directed at community programs for young people. Over 1 million copies have been distributed.

Mr. RANGEL. Assuming I am the director of a State drug program for the State of New York, and I want to go to my Federal Government and volunteer to participate in this war against drugs, what do I get from the Federal Government besides pamphlets and a list of volunteer organizations?

Dr. MACDONALD. You get a pretty strong feeling that we believe this war is going to be won in the communities, not here in Washington. We are here to support State and local initiatives. Education has to be built on data and we are accumulating that data as to the risks of these drugs.

Mr. RANGEL. Is this a national problem?

Dr. MACDONALD. Indeed, sir.

Mr. RANGEL. Today we are focusing on cocaine. Do you know of any coco leaves grown or produced on the local level?

Dr. MACDONALD. I know they are not grown on the local level.

Mr. RANGEL. If we are talking about a national problem, wouldn't you believe it would require a national solution?

Dr. MACDONALD. Demand reduction which is what we are addressing——

Mr. RANGEL. The demand part of the problem is local in your view?

Dr. MACDONALD. We have to have a national strategy.

Mr. RANGEL. What is the national strategy in providing direction, assistance, and resources to local and State governments?

Dr. MACDONALD. The national strategy is built on a belief that cocaine use follows the use of the other drugs which have been mentioned—alcohol, tobacco, and marijuana—that use begins early. For example the average age of beginning alcohol use is 12.6 years. If we are going to make an impact in prevention, we have got to deal with the adolescent. The best place to deal with the adolescents are in the schools and the homes.

Mr. RANGEL. On a national level, what are you doing?

Dr. MACDONALD. In the schools, providing data as to risk.

Mr. RANGEL. How is this data provided, Doctor? Is this a Federal program or do they write in for it? How is it provided? Where is the Federal presence in all of this?

Dr. MACDONALD. There is a national clearing house which provides data from both NIDA and the Alcohol Institute.

Mr. RANGEL. The Congressional Library provides data but it is no national program.

Dr. MACDONALD. I am really not trying to sidestep your question.

Mr. RANGEL. I don't think you are.

I think the fact is going to be proven that we don't have a national program, so I know you are not trying to sidestep it.

The second part of my question is, what can we do to improve upon the Federal reponse to this epidemic?

Dr. Mason, your statement is devastating in terms of what is going on and what we should expect. It was a very professional statement and consistent with all of the information we have been able to gather from whatever sources, including international sources. It is clear that our Government is fully aware of the depth of the problem of the cocaine epidemic, but what I don't understand is, our response to that challenge to us, the costs in terms of crime, loss of productivity, and the permeation of cocaine in the Armed Forces, Wall Street, in the board rooms. This is a threat to our national security, no matter how you measure it.

If I understand Dr. Macdonald, what he is saying is there is a general feeling this has to be handled on the local level, that we have literature that is prepared for those who want it, that symposiums are being held around the country for those who want to participate, but that is about the size of our national input.

Dr. MASON. Well, there is much more than that, Mr. Chairman, and I understand your concern, but first of all, until you understand the risk factors, you can provide all sorts of information at the local level but if the information is not based upon sound facts, without the data, without the surveillance, without the research—I agree that there has to be far more than that but if there is one Federal role——

Mr. RANGEL. Now the Federal Government had ample time to deal with the problems of heroin and there are no problems with heroin.

Dr. MASON. Well, there are programs. We know, just in the block grant funds, almost a half a billion dollars in block grant funds that are going to the States, and although Congress has determined that there will be few strings attached to those funds——

Mr. RANGEL. Well, the President has determined that he did not want categorical grants and the Congress supported the President, but you are a professional. Do you agree that there should not be any strings attached, any Federal guidelines, that we should let them do what they want to do?

Dr. MASON. For the reasons you have outlined, each community is different. Each application, each population, segment is different, and so the funds are provided to the States, almost a half a billion dollars, worth——

Mr. RANGEL. Is that any way to fight a war, Doctor? If we were being attacked by an outside force, do we allocate money to State governments and tell them, you should know what you need best?

We are talking about outside forces invading the United States of America in the form of cocaine and striking at the very vitals of our security.

Dr. MASON. And this is exactly why the symposia are being carried out to these communities where the number of cocaine users are high. It is an attempt to take into the community information, general principles that they can use.

Mr. RANGEL. There is no mandatory requirement that they participate?

Dr. MASON. No, there shouldn't be a mandatory requirement.

Mr. RANGEL. If we are talking about a national effort, why should we rely on the local communities as to whether they want to participate or not? We have a lot of poor States that pay very little attention to education and health problems, because of their low income communities and traditionally they have not been involved with it.

Dr. MASON. We have found, not just in drug abuse that until the local community says a problem is unacceptable, until they the community are going to do something about it, it doesn't matter what we do at the Federal level, in the absence of regulatory provisions that we don't have.

Mr. RANGEL. If you have strings attached to some of these federal funds, as we have in other categories—my last question is presented to me by the staff—NIDA's budget request for 1986 includes an estimated $3.2 million for extramural research on cocaine and other stimulants. The total budget for research for extramural research is $62.5 million.

In terms of program distribution, the cocaine research ranges six out of nine categories behind heroin, narcotics, basic research and marijuana prevention. Is this accurate?

Dr. MASON. Let me say why I think it is not accurate. We do not pinpoint most of our research to just one single drug. We have already tried to indicate that the drug abuse not single out just cocaine. The association with alcohol, with marijuana, heroin, and other drugs——

Mr. RANGEL. I will ask staff to give you a copy of your budget request.

Dr. MASON. I will ask Dr. Macdonald to give you the total amount.

Mr. RANGEL. This came from your department.

Dr. MASON. It is important to recognize that although the amount directly related to cocaine research may be that amount, that the good that is being done, comes from the research that is being done that is much broader.

Mr. RANGEL. Are the three of you satisfied that of the work that we are doing in the area of education and prevention, that we are fulfilling our national responsibilities to local and State governments, Dr. Macdonald?

Dr. MACDONALD. I think that cocaine abuse has come by storm, and I think we seriously need to look at the allocation of money within our budget, to see if we shouldn't be spending more of our intramural research resources on cocaine related research.

To answer Dr. Mason's, or the follow-up question, the 6 percent of our extramural program that is specifically cocaine and stimulants does not include the facts that we do some nonspecific risk factor research that covers it.

We do have a national problem. You don't like me coming back to the numbers, so I won't.

Mr. RANGEL. Dr. Snyder.

Dr. SNYDER. I think that part of the issue comes back to something you said earlier, and that was where you assumed that with regard to demand reduction activities NIDA or ADAMHA would be

the key focus. From a staff level, I have to always think of what is NIDA's mission.

Mr. RANGEL. I am dealing with the Health and Human Services, so I never said that it was NIDA. You are just one part of it. When we talk about demand, I am talking about Health and Human Services. You carry more than your load, you have been dramatically cut back. You used to be an agency that—well, anyway, you had a lot of capacity to do a lot more before they changed the manner in which you were supposed to provide the services, but still, it is Health and Human Services that I have to go to for prevention, education, treatment, and rehabilitation, not necessarily NIDA.

You can do your research but if the research means you come to a region, have a conference and invite people to come, they come, or don't come, then you fulfill your national responsibility, I differ with that.

Dr. SNYDER. In regard to the issue of a national strategy or material being disseminated, it is important to realize that there are treatment strategies that have been developed for cocaine that are published in the literature, and thus available for use of physicians all over the country. That is the same type of information dissemination and strategy that you will find with heart disease, or with cancer. It is the standard approach of getting scientific information out to the doctors in the field.

In terms of prevention, prevention is a very, very difficult item to get a handle on, in the sense of what works. We are still trying to develop the research base that will give us information about what does and does not work in prevention. You can go to a whole host of other diseases, where we know some things that will prevent the disease such as with cancer, and heart disease and it is very difficult to translate that information into programs so that people will change their behavior.

Prevention of drug abuse—that is you change people's behavior for their own welfare—is a science still in its infancy.

Mr. RANGEL. Well, we certainly are in infancy and I don't really think that our presence is felt.

What you are saying, Dr. Snyder, the Federal Government, not just NIDA, is researching the problem. You don't have an answer to it. You are researching it. You are telling people the results of your research and you believe that volunteer groups and local communities and local and State governments are going to have to wrestle with this thing and rely on us to give them the best possible information that we have from time to time.

Is that a fair summary of whatever——

Dr. SNYDER. It is a pretty fair summary at the end. We routinely and deliberately make sure the information is available.

Mr. RANGEL. I am telling you, we are going to pay for this approach in dollars and cents, productivity. We didn't do this with the military, we didn't run to HHS and say will you do some research as to what we can do in prevention? When our Air Force pilots were missing landings on carriers, we didn't ask you to research and to pass out literature and to invite the commanding officers—if they want to come, if not, what can we do—because we need their cooperation. We said that we cannot tolerate it in the

military. We had a program and went forcefully at it and we have had a great degree of success.

I wish that we had the same type of determination in battling this thing on the local level.

Dr. MASON. With all due respect, we don't have the same relationship to the States and local communities that the military has with their personnel. We have to recognize that.

Mr. RANGEL. You ask a mother that is dependent on a Federal contribution to her check, just how many controls we have on State government. We have programs operated out of your department under Federal regulation, aid to dependent children, and if you don't like the Federal rules, you don't apply for local assistance. So we do have the ties if we really weren't dealing with block grants.

Dr. MASON. You mean we place strings on the receipt of those checks? They undergo certain behaviors, educational programs, or else they don't receive a check? We would be happy to consider that further, if you would like us to.

Mr. RANGEL. Doctor, that is the most encouraging sign I have heard, but you have to answer whether you think that would be helpful, if you did have a Federal direction in terms of Federal dollars that were going to local and State governments.

If you believe that—let the local people decide what they want to do, then there is no sense considering it. If you do believe that we should take our research and not just have conferences, but to incorporate our recommendation, our direction in what we should be doing in our schools, based on our research, and say that if you want to enjoy the Federal dollar, you have to report as to how it is working, which means that you have a reservoir if information that is being fed back that can only improve the quality of research as to what you do in prevention.

Dr. MASON. That is very different from attaching certain demands to aid to families with dependent children payments, individual checks and things of that nature.

Mr. RANGEL. Well, I am talking about the money we sent out in a block grant that is being used for education and rehabilitation. You know, the way we used to have them. In any event, we have a long way to go. I will be glad to call the members of the committee that work with education and labor and work with the Health Committee, more closely with your departments to see whether or not there is a better way to deliver the services.

Dr. MASON. We are quite excited that with less than a half of a billion dollars in block grant funds, the States are now matching that with $1.3 billion of State funds. What we see is the Federal Government providing a certain foundation acting as a catalyst amount and then the States coming in with their own initiatives to increase the amount of money that is being used to attack the problems of drug and alcohol abuse. I think that is a very favorable sign.

Mr. RANGEL. It is for the States like New York that have the surpluses or that have the resources to do that, but even there, we have a 1,500 waiting list for those who want the rehabilitation in the city of New York, not just the State.

Larry, I am terribly sorry. I yield to you.

Mr. COUGHLIN. Thank you, Mr. Chairman.

I share some of the frustration of the chairman. I would like to focus for a minute on cocaine and education. We know it has been around for a long time. I remember a song called "Cocaine Bill and Morphine Sue." That was being sung when I was in college. We know it is addictive. We know it is dangerous. Yet, there is also a myth that it is not dangerous.

As I understand it, you have two specific things you are doing in the education field. One is you have prepared a resource package specifically directed to cocaine. Has that been made available to all the schools in the United States?

Dr. SNYDER. We can provide that information for you. Certainly it is available from our clearing house. Whether it is specifically targeted at the schools or other organizations, I could not say.

The cocaine resource package has been made available to the State authorities for drug and alcohol abuse and the State prevention coordinators through the National Prevention Network. The States use their own internal distribution systems to reach elementary and secondary schools. The distribution plan also includes associations such as the National Association of Elementary School Principals, the National Association of School Boards, the National Education Association, the National Association of Secondary School Principals, the National Association of Guidance Counselors, the National Federation of State High School Associations, and the National Parent-Teacher Association. These associations disseminate information to their membership. Information on the resource package will be made available to schools throughout the nation through these organizations' newsletters, magazines, and journals.

Mr. COUGHLIN. That is one thing being done. You have the resource package on cocaine. It is an educational resource package; am I correct?

Dr. SNYDER. I am not aware there is a formal package. We have a series of publications and material prepared on cocaine. If you want to call it a package, I am——

Mr. COUGHLIN. It was referred to as a resource package.

Dr. MACDONALD. There is one. I have a message that says that will be available through the States.

Mr. COUGHLIN. How do we make sure that gets to all the schools in the United States as quickly as possible?

Dr. MACDONALD. We will respond to that, if I may also. One of the problems we have in education is that is not just data, it is attitudes that are so important. We can send students and schools information however, if they don't have a local push to use it, it comes to no merit.

Mr. COUGHLIN. The myth that cocaine is not a very dangerous substance has been fairly recently pierced. You have information that backs that up and needs to be gotten out and disseminated as broadly as possible, to schools as quickly as possible. I am trying to find out what is being done to make sure that it is in every school in the country.

Dr. MASON. We will supply that for the record. That is an excellent question.

Mr. COUGHLIN. The second program you mentioned is the media campaign through the Ad Council, which I commend you on. That will go into place in 1986, as I understand it. How extensive is that campaign? That has to be terribly important. Is it focused on cocaine?

Dr. MACDONALD. The dollar amount will be supplemented by the Ad Council tremendously. NIDA is putting in $642,821 through a 29 month contract. It is specifically cocaine.

Mr. COUGHLIN. How extensive is the program?

Dr. MACDONALD. I am not sure what you are saying.

Mr. COUGHLIN. How many stations in the country will use it? How many—whatever you call them—points are you putting across? How many cities?

Dr. MACDONALD. Again, we will have to provide that for the record.

The cocaine media campaign package will be sent to 820 television stations and 6,500 radio stations (6,000 commercial and 500 public) throughout the United States.

I think what we found encouraging—and Mr. Keach spoke about it—is that the entertainment industry is supporting us in efforts to get the message across. We are sure the video tapes will be good. Where they will be shown is harder to determine.

Mr. COUGHLIN. How many dollars do your have devoted to the campaign?

Dr. MACDONALD. We will be providing almost $643,000 over 2 years.

Mr. COUGHLIN. Is that production cost?

Dr. MACDONALD. That doesn't cover the full production costs. The Ad Council will make a contribution in kind.

Mr. COUGHLIN. You don't have any kind of schedule that has been produced so far by the Ad Council or anyone else as to how frequently these will be shown and in what markets?

Dr. MACDONALD. They can't guarantee how many TV stations will pick them up and show them. We do have a production schedule of when we hope to have the materials available. They will be available to all States and we will encourage their use. I don't know that we can guarantee that TV stations are going to run them.

Mr. COUGHLIN. What I am trying to say is that such a good job has been done on the drunk driving campaign across the country in this very way. If that is not being pounded home now, I miss my mark. The problem of cocaine involves a myth that needs to be burst. Drunk driving was the same kind of problem—because we didn't realize how many accidents were involved in drunk driving, and we don't know how many serious health injuries are being caused by cocaine. Somehow the same sense of urgency doesn't seem to be there.

Dr. MACDONALD. It is on my part, and on Secretary Heckler's part this is important. I know she has committed herself strongly to getting the message out about the dangers of drug abuse. The drunk driving campaign is a grassroots effort. As, I said in my earlier testimony, that is where the power is. When parents become involved, they push and do a more effective job than we do.

Mr. COUGHLIN. It was a combination effort. I sit on the Transportation Subcommittee. It was a combination of grassroots and a mandate from the Federal Government and a great deal of push from the Secretary of Transportation to get this across. It was a major priority. I think we have to make cocaine, because of the

new information we have about its danger and its addictiveness, a major priority.

Dr. MASON. There is no question there has to be an effort at every level—Federal, State, and local. Without this, we will not win this war.

Mr. COUGHLIN. Thank you, Mr. Chairman.

Mr. RANGEL. Thank you.

In response to Mr. Coughlin, Dr. Mason, I missed the question, but I did hear you say that for the record you were going to share with us how information would be distributed to the classroom?

Dr. MASON. We would be happy to share with the committee the plans that we have for distribution of those materials.

Mr. RANGEL. I may owe you an apology. Is there anything you are doing now to distribute any information to the classrooms? I mean, not what you are going to do, is there any program that you have that you can say that every teacher has a piece of Federal literature that deals with this problem that we hear about?

Dr. MASON. Let me say that in the broader field of risk reduction that is talking about health promotion where we are dealing with tobacco, alcohol, drug abuse—broadly conceived, then within the Department of Health and Human Services we have a lot of major efforts.

Mr. RANGEL. I see. But nothing specifically with drugs?

Dr. MASON. Yes, targeted at tobacco, alcohol, and drug abuse, generally conceived—marijauna, cocaine, heroin.

Mr. RANGEL. What would be the literature I could depend on that my teachers have in New York?

Dr. MASON. Teachers in New York should learn about the cocaine resource package through the efforts of John S. Gustafson, Deputy Director, Division of Substance Abuse Services. He will use his existing contacts with school systems to announce the availability of this resource package. Materials have been developed by CDC relating to risk reduction. There are pilot programs used in many communities to implement this kind of an approach to risk reduction. Evaluation studies have been done to show there is a decrease in the use of tobacco and alcohol and drugs when these approaches are used and those are now being distributed through the State and local health departments. They have been delivered to State health departments, who in turn take them to their State school programs who deliver them through that channel. That is being done as a nationwide effort.

Mr. RANGEL. Mr. Coughlin responded to Dr. Macdonald's confidence in grassroots system that the grassroots people are looking for a national direction. You have to give them encouragement, incentives. He spoke about what has happened, how it has worked. Sure, you cannot just have a Federal program and no one down there wanting to implement it.

But I have been looking over your outstanding background, Dr. Macdonald. You are basically an outstanding professional with deepseated grassroots ties. All the things that you have been doing in Florida, you have been doing with people, not just national organizations, and working with the children and the services, nutrition consultant, lecturing, a medical advisory committee, numerous other committees in Clearwater.

Would not your Government have been able to give you a lot more encouragement if they could give you the resources so all this work you have been able to do would have been more encouragement to you in Florida?

Dr. MACDONALD. I guess one of the reasons I am happy to be here is that I do intend to offer encouragement to those grassroots movements. When we talk about education, I am delighted Time magazine has cocaine on the cover, and Newsweek. This is an effort we all need to be involved in.

Mr. RANGEL. You recognize, Doctor, the only reason I am here is because I am a part of the Government, not the board of directors of Time. I want to laud all of them. I want to take this opportunity to congratulate the Advertising Council and NIDA for the wonderful work they are doing in the private sector. And the witnesses we have had this morning, non-Government witnesses, we have to congratulate them. I am just restricted in being concerned about what we are doing.

Let me thank you. We hope to have some informal sessions. Maybe we can work out something a little easier without the tables between us.

Dr. MASON. We thank you for the leadership that you are providing.

Mr. RANGEL. Thank you, Doctor.

We stand adjourned, subject to the call of the chair.

[Whereupon, at 1:15 p.m., the committee was adjourned, subject to the call of the chair.]

[The following statements were submitted for the record:]

OPENING STATEMENT OF
THE HONORABLE CHARLES B. RANGEL

GOOD MORNING. TODAY THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL CONVENES TO HEAR FROM OUR WITNESSES OF DIFFERENT BACKGROUNDS AND WALKS OF LIFE ON THE SUBJECT OF "COCAINE ABUSE AND THE FEDERAL RESPONSE." THE HEARING WILL FOCUS ON THE MEDICAL AND SOCIAL IMPACT OF THE COCAINE EPIDEMIC WHICH BY ALL ACCOUNTS IS WORSENING IN THIS COUNTRY; AN ESTIMATED 25 MILLION AMERICANS ARE USERS OF COCAINE AND 5,000 PEOPLE EXPERIMENT WITH THE DRUG EVERY DAY. MANY OF THESE NEW USERS WILL BECOME DEPENDENT TO THE POINT OF ADDICTION ON THIS, THE 'FRUIT' OF THE COCA PLANT WHICH GROWS SO ABUNDANTLY ON THE HILLSIDES AND IN THE VALLEYS OF COLOMBIA, BOLIVIA AND PERU AMONG OTHERS 'FRIENDLY' TO THE UNITED STATES. MANY OF THESE NEW USERS WILL COME TO KNOW THE TRAGEDY AND ANGUISH THAT THE WHITE POWDER BRINGS. A STUDY PUBLISHED JUST LAST WEEK IN THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION FOUND THAT COCAINE, WHEN USED REGULARLY FOR PROLONGED PERIODS, MAY BE MORE LETHAL THAN HEROIN.

THE BELIEF THAT COCAINE IS THE TOY OF THE WEALTHY AND WELL-EDUCATED HAS BEEN SHATTERED. MANY BLUE COLLAR WORKERS AND YOUNG PEOPLE ARE USERS TODAY. SOME OF OUR WITNESSES TODAY WILL ELABORATE ON THOSE FACTS.

53-440 O - 86 - 3

THREE WHO KNOW ALL TOO WELL THE DEVASTATION OF COCAINE ABUSE JOIN US THIS MORNING. LET ME THEN WELCOME THEM AND INTRODUCE EACH FOR THE RECORD. STACY KEACH. MR. KEACH, IS AN ACTOR OF WORLD-WIDE RENOWN AND STAR OF CBS-TV'S "MIKE HAMMER" TELEVISION SERIES. HE WAS RELEASED LAST MONTH FROM A SIX-MONTH JAIL TERM IN ENGLAND FOR POSSESSION OF COCAINE. HE COMES TO US THIS MORNING TO MAKE HIS FIRST PUBLIC STATEMENT ON HIS COCAINE PROBLEM. CARL ELLER. CARL, TWICE AN ALL-AMERICAN IN COLLEGE WAS AN OUTSTANDING DEFENSIVE END FOR MINNESOTA'S FOOTBALL VIKINGS FOR WHOM HE PLAYED SOME 14 YEARS. IN THAT TIME HE WAS NAMED ALL-PRO FIVE TIMES AND WAS THE LEAGUE'S "MOST VALUABLE LINEMAN" TWICE. FOR NINE YEARS COCAINE WAS A PART OF HIS LIFE. HE IS NOW A CONSULTANT TO THE NATIONAL FOOTBALL LEAGUE ON DRUG AND ALCOHOL ABUSE. BERNICE CARRINGTON. MS. CARRINGTON IS BEFORE THE COMMITTEE TO TELL ABOUT HER PERSONAL EXPERIENCE WITH COCAINE. SHE IS NOW EMPLOYED BY ONE OF WASHINGTON'S MOST PRESTIGIOUS FINANCIAL INSTITUTIONS. SHE KNEW THE PAIN OF COCAINE FOR NINE YEARS. INDEED STUDIES SHOW THAT MORE WOMEN THAN EVER BEFORE ARE GRIPPED BY COCAINE ADDICTION.

THE COMMITTEE HAS INVITED THE THREE MEMBERS OF OUR FIRST PANEL THIS MORNING, NOT TO POINT A FINGER AT AN ADMINISTRATION SEEMINGLY UNABLE TO SHUT OFF THE SOURCE OF SUPPLY OF COCAINE TO THIS COUNTRY OR SEAL OUR BORDERS FROM ITS ILLEGAL IMPORTATION, NOT TO PROVIDE A PLATFORM FOR AN EXPRESSION OF OUR WITNESSES' REMORSE. YOU, MR. KEACH, MR. ELLER AND MS. CARRINGTON, HAVE

BEEN ASKED TO APPEAR BEFORE THE SELECT COMMITTEE SO THAT WE MAY COLLECTIVELY AND MORE SUCCESSFULLY REBUT THE GLAMOROUS IMAGES AND MYTHS CONCERNING COCAINE. WE ARE SUBJECTED, WITH ALMOST DAILY REGULARITY ON TELEVISION, IN THE MOVIES, IN THE PRINT MEDIA, TO THE IMPRESSION THAT COCAINE IS SOMEHOW A SAFE, RECREATIONAL DRUG. WE WISH TO HIGHLIGHT FOR THE PUBLIC THE DANGERS OF COCAINE USE.

THE FACT IS THAT COCAINE IS POISON AND IT KILLS. THE NUMBERS REPRESENTED ON THE CHARTS DISPLAYED AROUND THE HEARING ROOM REFLECT THE VERY REAL THREAT THAT THE DRUG IS TO THE HEALTH OF THOSE WHO ABUSE IT. THE PRICE OF COCAINE HAS FALLEN AND IT IS READILY AVAILABLE ON THE STREETS. THE GOVERNMENT'S OWN DATA SHOW THE NUMBER OF COCAINE DEATHS HAVE SKYROCKETED FROM 129 IN 1979-80, TO 456 IN 1983-84. THE NUMBER OF EMERGENCY ROOM EPISODES INVOLVING COCAINE DURING THE PERIOD TRIPLED. AT THE SAME TIME FEDERAL SUPPORT TO THE STATES FOR DRUG ABUSE PREVENTION AND TREATMENT ACTIVITIES HAS FALLEN. THE TOLL IN TERMS OF WORK PRODUCT LOST, LIVES WASTED, INCREASED CRIME STATISTICS, ETC. TAKEN BY THE 85 TONS OF COCAINE, THE COMMITTEE ESTIMATED TO ENTERED THE U.S. LAST YEAR IS IMMEASURABLE.

IN LIGHT OF THESE GRIM STATISTICS, WE WILL EXAMINE THE EFFORTS BEING MADE TO ADDRESS THE TREATMENT OF THOSE WHO SEEK TO RID THEMSELVES OF THIS DEADLY ADDICTION. THREE OF THE NATION'S FOREMOST EXPERTS ON COCAINE TREATMENT WILL THUS TESTIFY THIS

MORNING. ARNOLD WASHTON WHOSE ORGANIZATION, THE COCAINE HELPLINE RECEIVES UP TO 1,200 CALLS FOR HELP EACH DAY, DR. RONALD DOUGHERTY OF THE BENJAMIN RUSH PSYCHIATRIC CENTER IN SYRACUSE, N.Y. WHO HAS PIONEERED EFFORTS IN COCAINE TREATMENT AND RICHARD HAMILTON, DIRECTOR OF THE MARYLAND DEPARTMENT OF MENTAL HYGIENE JOIN US TO DISCUSS TREATMENT INITIATIVES IN LIGHT OF THE ADMINISTRATIONS'S REDUCTIONS FOR DRUG ABUSE TREATMENT EFFORTS.

SPEAKING THIS MORNING FOR THE REAGAN ADMINISTRATION WILL BE JAMES O. MASON, ACTING ASSISTANT ADMINISTRATOR FOR HEALTH AND HUMAN SERVICES. MR. MASON WILL BE ACCOMPANIED BY DR. IAN MCDONALD, ADMINISTRATOR FOR THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION AND DR. MARVIN SNYDER, DIRECTOR, PRECLINICAL RESEARCH, NATIONAL INSTITUTE ON DRUG ABUSE. TESTIMONY TO THE PUBLIC HEALTH PROBLEM CREATED BY THE DRAMATIC RISE IN RECENT YEARS OF THE ABUSE OF COCAINE.

WITHOUT FURTHER DELAY, ON BEHALF OF THE SELECT COMMITTEE, I WELCOME YOUR TESTIMONY.

Statement of Carl Eller
to the
House of Representatives,
Select Committee on Narcotics Abuse and Control

HEARINC ON COCAINE ABUSE AND THE FEDERAL RESPONSE

Introduction:

It is indeed a pleasure and an honor to be asked to speak to the Select Committee on Narcotics Abuse and Control.

I equate my feelings for this opportunity with those that Mahatma Ghandi, Sigmund Freud, Albert Einstein and Gloria Steinem must have had. I relate to these people because I know how difficult it is to break new ground and change old habits, to give someone new concepts and to replace traditional thinking. I feel this is the journey I embark upon at this hearing.

The ideas I present to you today are my own. Forged from my own personal experiences and supported with much work and factual data collected over a period of years, my research has included surveys and questionnaires; personal interviews, plus information from one-on-one and group counseling sessions with athletes.

It is my desire to provide some answers to the question of why there are so many problems with drug programs for athletes.

My personal and professional background is athletics. I have 23 years as an active player covering high school, college, and 16 years with the National Football League. I was honored with the highest awards from my peers and superiors at all levels, and as a professional I was voted twice best at my position. In addition to that I have had 4 years as a counselor to athletes, assisting many in life-threatening situations caused by personal problems and/or chemical misuse and other difficulties. I am also certified as a chemical dependency practicioner and licensed as an employment counselor.

Although I have had experiences in law, psychology, medicine, and economics, I consider my background and expertise, as I said, to be in athletics.

It is from this stance that I approached Mr. Pete Rozelle, Commissioner of the National Football League, with the idea of implementing a program to assist professional football athletes suffering from chemical abuse. I shared with him my own addiction to cocaine and other personal problems at this time. Such a program required a major change in philosophy and attitude by the National Football

League management and a definite change in League policy. This change was from one of punishment to accepting chemical dependency as an illness. The Commissioner accepted a proposal of a pilot program for presentation to five NFL teams: the Miami Dolphins, Minnesota Vikings, Cleveland Browns, Oakland Raiders, and the Dallas Cowboys. This program later expanded to be accepted by all 28 teams and evolved into the present alcohol and drug programs of the NFL and NFL Players Association. Although this program has been endorsed by the NFL Players and NFL Management Council, there is still some concern that there needs to be more work done to make it more tailored to the needs of the athletes.

I continue to be associated with the NFL in an effort to reduce chemical abuse by athletes at all levels through my role as a consultant on matters of alcohol and drug abuse. In this capacity, I am utilized by players, teams, coaches, and families for intervention, counseling, referral, and aftercare for athletes with chemical dependency problems. I also conduct drug education and awareness programs for the NFL at high schools and colleges nationally. In my work as a consultant to the NFL and other professional endeavors, I am made aware of the resources available to treat the type of client that I deal so closely with, the chemically dependent athlete. Fifty-four percent of the players in the NFL are black; 85% come from

impoverished backgrounds. Many of them come from one of the 53 million single-family homes, and about 80% of those that are married, divorce before their playing careers are over.

Of the athletes in my care, nearly 100% of them began drinking alcohol in high school. Approximately 60% of them smoke marijuana and just under 22% began cocaine use in high school and early college years. Drugs other than alcohol increased significantly at the college and pro level.

In qualifying facilities to treat these individuals, very few had anyone to treat the minority player. Less than 12% offered financial or career counseling. And about 70% were more equipped to treat patients who abuse alcohol. Approximately 90% offered aftercare that consisted entirely of AA, NA, Alanon, Al-ateen, couple and family counseling on chemical abuse, and nothing on the specific problems of the professional athlete.

Only a handful of the approximate 9,000 facilities or agencies that exist in the United States which treat alcohol and/or drug addiction were aware of or had considered the development of a program for athletes and their unique set of circumstances.

The single most significant reason that drug programs in professional sports are unsuccessful is that they do not meet the needs of the athlete. At least one major league official, Mr. Peter Uberoth, Baseball Commissioner, has admitted that their program is not working.' Most of these programs are destined to fail from the start.

We must understand; athletes at the professional level combine the skills of many professions to be successful. To some extent they have had to develop medical, psychological, sociological, theological, financial, and legal acuity.

The major sports enterprise in America is divided into four professional leagues (baseball, basketball, football, hockey) consisting of 97 teams and employing some 2,755 athletes.

By contrast, there are more law firms than there are players in major league sports: 2,800 law firms.

There are over 2,500 colleges and universities in this country. Or looking at it another way, there are as many college presidents as there are professional athletes.

There is one major hospital for every 3 professional athletes, and for each individual who plays the position I played, there is at least one airline company operating in the United States.

Of the more than 60,000 corporations that operate in the United States, many have multiple departments and branches which are themselves corporations. To be in the top 1,000 is considered to be elite. Whereas in pro sports, there are only 22 in football, 12 in baseball, 6 in hockey, and 5 in basketball for a total of 44 athletes that really stand out.

Anyone educated in these other disciplines without experience as a professional or world class athletes would have a difficult time comprehending the perspicacity required at this level. To claim expertise without this experience is an insult to the athlete's intelligence and borders on asininity.

I have heard a physician say on network television that the reason for our nation's drug problem is because of our professional athletes. How they became licensed experts I'll never know. But many who present themselves as sports experts have been only as close as their television sets. In essence it would be like me saying, I can become a trial lawyer by watching a few episodes of "Peoples Court" or a

surgeon after devoting my afternoon to "General Hospital." Both television shows have a loyal audience, but watching alone does little to convert them into skilled lawyers or physicians.

Many of the problems of pro athletes begin in college. Can you imagine the dean of a medical school recruiting a brilliant young scholar and offering him or her a scholarship to attend their school to do extensive research writing elaborate papers for the department and bring numerous honors, then say to him or her, "I cannot give you a degree in medicine, you will have to get it in something else even though I know your desire is to become a doctor."

The athlete is the most discriminated person in our society today. Most people see the athlete as a highly paid professional, they do not think of him as the kid next door. We have over 30 million young people involved in sports, an experience that many Americans have had in their own lifetime. The reason people do not understand athletes or athletics is because there is really no way to become educated. The only opportunity for education in professional sports is to be involved in professional sports. It would provide a tremendous benefit for athletes to receive a degree in athletics.

A degree in athletics as a profession is just as valuable as a degree in science, medicine, history, or economics, and specifically considering the many benefits that athletics offers the rest of society.

A degree in science, medicine, history or economics, however, does not necessarily give anyone expertise in athletics. There is really no substitute for the knowledge from this experience. However, I am frightened by many of the things that I see people attempting to do with athletic programs around the country.

I think we are sincerely lacking in the amount of expertise that is necessary to develop our young athletes into our citizens of tomorrow.

Q: Ask any college president what courses they offer college athletes to prepare them for professional sports.

A: The answer, of course, is none.

Q: If you were to ask the college athlete whether their choice of schools had anything to do with anticipation of playing sports or for some other economic benefit, I am sure you would find many would say, "yes."

A: I do this to demonstrate that we are far from addressing the problems of the elite or professional athlete, and that we have isolated the athlete from society so totally that it is impossible to distinguish how severe drugs or any other problem really is.

The problem is not drug abuse, the problem is exploitation. Not of the athletes, but of the community. An exploitation of the tremendous investment in raw material in the youth of our country who aspire to become athletes or who are inspired by athletes to become something more than they might have become otherwise.

The opportunity for success is so narrow, the chances so slim, and the odds are so overwhelming that for everyone who makes it, there are thousands who do not. And for everyone that makes it and fails to return to the community because of drug abuse, it is even worse. If they fail to bring that investment back into the community, then it is the community that has been exploited.

In a "Comparison Study of Marijuana Use of Athletes to Non-Athletes" developed by the UNITED STATES ATHLETES ASSOCIATION, an organization which I founded to help young athletes develop leadership and to live balanced lives

while still getting the benefits of sports participation, the following statement illusttates the commitment of a USAA member:

"I(we) am(are) committed to the USAA mission: to enhance the integrity of sports, to provide youth with the opportunity to achieve excellence in athletics and education, and to prepare for careers beyond sports. I believe strongly in the benefits of athletic participation for developing our youth, and helping them live a positive chemically free life.

I(we) will support the USAA:

1. to develop leadership through athletics

2. to increase opportunity for sports participation

3. to promote a balanced life that includes a lifetime of sports and physical fitness

4. to activate a "chemically free life style"

Comparison of Marijuana Use of Athletes to Non-Athletes

Times Used	Non-Athlete	Athlete	Total
Never use:	42	46	88/47%
Once in 12 mos:	15	17	32/17%
3-9 times in 12 mos:	9	11	20/11%
10-39 times in 12 mos:	9	10	19/10%
Over 40 times in 12 mos:	3	4	7/ 4%
Once a week:	15	10	23/12%
Column Total:	93	98	189
	48.2%	51.9%	100%

As you can see from these figures, there is very little difference between us among athletes and non-athletes.

By contrast in their student assistance program there was a vast difference in the number of students that saw the counselor in the year prior as did the following year after we had initiated the program.

Comparison of Athlete to Non-Athlete of Student Assistance Program One Year Year After PROJECT TRIUMPH

Athletes in school: 51.9% of Student Population

	1985	1984		Increase
Number who saw counselor:	50	27	=	23
Number of referrals from coaches:	5	2	=	3
Number of referrals from teachers:	15	9	=	6
Number of referrals from peers or self:	30	16	=	14
How many non-athletes saw counselor:	150	135	=	15
Percent of athletes:	25%	16%	=	64%
Total number of students:	200	162	=	38

Our athletes do use drugs. They are doing about the same rate as the other kids, and you would expect to have the same amount of problems, yet they do not seek help at the same rate as the other kids. The problem being that

they feel that they will be jeopardizing many of their opportunities for a career advancement in sports. Further, the athlete is expected to assume total responsibility to be role models for other kids, when, at the same time he wants to join them and belong to their group without this punishment. To thrust this responsibility upon him without the support, training or education to assist him in handling this responsibility is foolish. If we cannot prepare him then I think we will continue to see an increase in chemical abuse.

Not only have I developed programs for the young athletes, but for the professional athlete as well. GAME PLAN II, a program used with the Minnesota Vikings this off-season does just that. GAME PLAN II helps them prepare for that responsibility. GAME PLAN II gives the professional athlete a chance to be normal. GAME PLAN II is an exceptional program for exceptional people to give them a better than average chance against drug abuse.

I developed this program because I realized that when the athletes were not taking care of themselves, they were in fact bringing harm to themselves. Much of it in the form of alcohol and drugs.

But, GAME PLAN II does a lot more. It gives them a chance to live. Many athletes have died from a syndrome I call "Hero-lism," the voluntary effort toward self-destruction. They have died as much from that as they have from drugs. Bill Robizen, a basketball player, committed suicide from carbon monoxide poisoning; running his car in his garage - he couldn't handle it and there was no help. Larry Mickey, hockey player for the New York Rangers, committed suicide after not being able to make the adjustment to the world from pro life; the world of fantasy to the world of reality. Jim Tyrer, Kansas City Chief football player, committed suicide because the glory of the game did not follow him off the field. Big Daddy Lipscomb died from an overdose of heroin trying to make the two worlds come together.

So you see, I'm not the only athlete that has had problems with alcohol and drugs. But there are many problems outside of alcohol and drugs and I think that many of these problems lead to the abuse of alcohol and drugs.

But I want to say that I am one of the more fortunate ones. I have had a bout with alcohol and drugs and, I have overcome it without dying or ending up in jail.

More importantly, I am able to give something back to the community. I am grateful for the many wonderful things that have happened to me in my life. And athletics has been one of them. I made mistakes that were very, very costly. Mistakes that I hope never to make again. My involvement with cocaine certainly ended my career prematurely; caused me tremendous financial and personal loss. But these problems are behind me. And any human being that has lived for any length of time has made at least a few mistakes, but it is not, however, the mistakes that are so important, but what I have learned from them that I can help other athletes, male and female athletes to avoid repeating them.

It is also a double mistake when we try to treat athletes the same as we treat everyone else with chemical problems, because of the way those chemical problems came about. They got them by being treated special; by being treated differently; by being set aside; by going through programs that were set up differently for them than everyone else in their same circumstances. And it is a mistake to also treat all athletes the same. They are different within their own groups. There is no sub-group of athletes, each level is different at the high school, college, and professional level. They all have their own needs and own way of dealing with their own special problems. They need personal skills. They need life organization. They need balance in their lives. Because at some point, without this

balance many of these athletes will cross the threshold. One that will take them into a journey of sports where they will stop being simple humans and they will start playing the role of being a hero. This hero role can be tremendously painful, if by some chance you do not live up to it.

The athlete has to see his life as a full life and not concentrate on just that one moment of peak performance. Because it may be that ultimate performance that gives him that ultimate high that can be achieved on the athletic and playing fields that he will seek to repeat off the playing fields to keep the glory when the glory is long gone and he is not able to face the reality of being who he really is.

The truth is that when trying to deal with the athlete, you cannot cure someone if you don't know who you are treating. To know what it is like to be a player, is to be a player, nothing else can give you that experience. Not watching, not cheering, not running along in the same company.

Athletes actually become addicted to the sport. It develops a syndrome called "Hero-lism." And the only way to prevent it is to make sure they are prepared to walk away from athletics.

Five million young people fighting for 500 spots. Pro athletes live in a fantasy world where from the age of 14 or so they have been taken care of. Reality is that athletes have 24 hours in each day, the same as anyone else. And when they are not playing their sport or playing the role of a hero they have to find some way to fill their time. A lot of them fill their time doing drugs ... once you get hooked, it's hard to get off. It's hard to get off of sports; it's hard to get off of drugs.

Again, my personal experience has been the teacher. And I know that chemical dependency or addiction to any drug, especially cocaine, can be a killer.

Chemical dependency is our nation's 3rd leading cause of death. And to some extent we are killing many of our young athletes by denying them the ability to get the help that they need and deserve for their problems with alcohol and drugs.

My strong feeling is that we must create new educational programs that will help us to establish our youth on a firm footing in life. A firm footing that will preclude the need for mind altering substances. Some examples of programs are:

1. Establish a USAA chapter in every United States high school, every college, every university.

2. Teach athletes the laws of sports:

   Prepare for early retirement
   Learn how to maintain your mind + body at optimum fitness
   Learn techniques for improving professional skills
   Learn how to live a balanced life - put sports into perspective

3. Establish a college curriculum that will educate the athlete in the areas of:

   Financial planning and responsiblity
   Leadership - what it requires of you, and how to meet its challenge.
   How to meet and respond to the public
   Life balancing - how to structure your life outside sports
   Principles of stress management - how to cope without "crutches"

4. Professional teams should show leadership in preparing a plan for returning athletes to the community in some productive capacity after a sports career.

5. Establish a National Institute of Sports and Humanities, which would serve as a think-tank for coaches and athletic administrators to research moral and ethical issues of professional sports as part of the American scene.

6. Include professional athletes on all committees, advisory bodies, regulatory or governmental commissions, college and university policy-making boards, so that they can provide input into the resulting rules and regulations affecting them and their careers.

Your help in bringing this to pass will result in thousands of lives being reclaimed for productive contributions to the American way of life and thousands more who will never become addicted.

For more information contact:

Carl Eller, Director
United States Athletes Association
Post Office Box 11337
Minneapolis, Minnesota 55411
1-800-328-3890, extension 6010 or
(612)529-7279

U.S. House of Representatives

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
WASHINGTON, D.C.
Charles B. Rangel, Chairman

SPECIAL HEARING ON:
THE COCAINE ABUSE PROBLEM IN THE U.S.
July 16, 1985

TESTIMONY OF

DR. ARNOLD M. WASHTON
DIRECTOR OF RESEARCH
NATIONAL COCAINE HOTLINE, *"800-COCAINE"*
FAIR OAKS HOSPITAL, SUMMIT, NEW JERSEY
AND
DIRECTOR OF ADDICTION RESEARCH AND TREATMENT
THE REGENT HOSPITAL
NEW YORK, NEW YORK 10021

Telephone number: (212) 935-4931

Biographical sketch
DR. ARNOLD M. WASHTON

Dr. Washton is Director of Research for the National Cocaine Hotline, *"800-COCAINE"*, at Fair Oaks Hospital in Summit, New Jersey, and Director of Addiction Research and Treatment at **The Regent Hospital** in New York City.

A nationally-recognized expert in the drug abuse field, Dr. Washton has published numerous articles in leading medical journals and books; serves on federal, state and local advisory boards; and, has received research and fellowship grants from the National Institute on Drug Abuse and the National Institute on Mental Health. He is an active participant in the parents movement against drugs.

Dr. Washton is best known for his clinical research in developing new treatments for drug abuse problems, including innovative studies on the use of clonidine and naltrexone as the first effective nonaddictive treatments for opiate addiction. More recently, he has achieved national recognition as a leading authority on cocaine abuse. He established the first cocaine hotline in the U.S., before becoming Director of Research of the 800-COCAINE Hotline, and also established the nation's first specialized cocaine abuse treatment center at The Regent Hospital in New York. He appears frequently on TV and radio programs speaking on the topic of drug abuse prevention and treatment and maintains an active schedule of public speaking to professionals, community groups, and business leaders.

Dr. Washton had previously testified before the Select Committee on Narcotics Abuse and Control in 1983 and has also terstified before the President's Commission on Organized Crime, the New York State Senate, and the American Bar Association at public hearings on the cocaine problem.

CONTENTS OF TESTIMONY

1. SCOPE OF THE PROBLEM

Cocaine use in the U.S. has reached epidemic levels. Government surveys indicate that over 25 million Americans have already tried cocaine; 5-6 million use it "regularly"-- at least once per month; and, 2-3 million are addicted to the drug , unable to stop using it despite serious physical, mental, and social consequences. In only the past three years , cocaine-related deaths and emergency-room visits have increased over 200% and requests for treatment have increased over 600%. Among high school seniors, cocaine use has risen sharply from 6% in 1976 to over 20% at present. U.S. citizens consume over 50 metric tons (110,000 pounds) of cocaine per year and spend over 50 billion dollars for the drug. Cocaine trafficking has become one of the most lucrative businesses in our nation.

Our National Cocaine Hotline, ***800-COCAINE***, has received over ***one million calls*** from all across the country since it was first started in May, 1983 - only two years ago. The volume of calls to the Hotline continues at a rate of over ***1,200 per day*** with no tapering off in sight. This toll-free service operates 24 hours a day, staffed by professionals, recovering addicts who complete intensive training, and grateful family members who donate their time. The enormous response to the Hotline is itself a testimony to the scope and seriousness of the cocaine problem in the U.S.

2. MYTHS vs. FACTS

Myth: ***Cocaine is nonaddictive and relatively harmless.*** Most who try it believe they will have no difficulty in controlling their use and will not suffer any adverse effects. Cocaine is thought to be a benign "recreational" drug that can be used for its euphoric pleasures without serious risk of addiction or medical consequences. In this regard the public perception of cocaine is very similar to that of marijuana.

Myth: ***If you "just" snort cocaine you won't have problems with it.*** One of the most dangerous and inaccurate myths about cocaine is

that the intranasal method of use ("snorting") provides the user with an inherent protection against developing an addiction to the drug or suffering toxic and fatal reactions. It is commonly believed that only those who freebase or inject cocaine experience problems.

Facts: The popular beliefs about cocaine that contribute to its widespread appeal and the willingness to try it, are challenged by our observations over the past few years. Some of the facts about cocaine are as follows:

1. Although cocaine does not usually produce a dramatic withdrawal syndrome like heroin, there is no doubt that ***cocaine is addictive***. This addiction is due to physical alteration in the user's brain chemistry and is characterized by three major features: (1) a loss of control over use of cocaine; (2) craving and compulsion to use it; and, (3) continued use despite adverse consequences. Like alcoholics and other drug addicts, cocaine abusers tend to deny that they have a drug problem and show distortion of their priorities and values. Over 85% of Hotline callers say they feel addicted to cocaine, cannot limit their use, can't refuse cocaine when offered, and prefer cocaine to food, sex, family activities, and sports.

2. ***Taking cocaine stimulates the desire to take more cocaine***. The cocaine "high" is very brief, lasting only 20-30 minutes, and is followed almost immediately by an unpleasant depressive reaction called the cocaine "crash". The user is driven to repeatedly take cocaine in order to restore the pleasant euphoria and alleviate the unpleasant "crash". Cocaine has a powerful influence on reward centers in the brain and is capable of replacing the normal survival-oriented basic drives (such as hunger, thirst, sexual desire, etc.), with the desire for cocaine.

2. ***Tolerance*** to cocaine develops with repeated and chronic use. The diminishing euphoric response to cocaine drives the user toward more intensified patterns of use in an obssesive chase to recapture the original "high" remembered from the beginning stages of use. Tolerance to cocaine is evident from the fact that chronic users escalate to dosage levels that would have been fatal at the beginning stage of use.

3. ***Withdrawal symptoms*** from cocaine are most clearly evident in high-dose chronic users, especially those who freebase or inject cocaine. These symptoms include post-cocaine depression, insomnia, agitation, restlessness, appetite disturbance, and incoherence, lasting for 3-5 days after cessation of use.

4. ***Animal experiments*** demonstrate the addictive power of cocaine most dramatically:

- Animals will choose cocaine in preference to any other drug made available to them, including heroin and morphine.
- Animals given unlimited access to cocaine will take such massive doses

of the drug that in over 95% of cases they induce in themselves fatal brain seizures and die within 30 days. With other addictive drugs this rarely happens.

- Hungry animals given the choice of cocaine or food invariably chose cocaine and ultimately die of starvation or toxic drug reactions.
- Animals will work to the point of total exhaustion, pressing a lever over 13,000 times to obtain a single dose of cocaine.
- Monkeys will reliably chose to press a bar that gives a high dose of cocaine followed by a painful electric shock in preference to one that gives a lower dose of cocaine with no shock.
- Sex-deprived male rhesus monkeys will choose to press a bar for cocaine injections in preference to a receptive female monkey placed in their cage.

5. Although not everyone who tries cocaine becomes addicted or suffers medical consequences, this does not mean that occassional cocaine use is completely "safe". Even infrequent use holds many dangers that are not sufficiently recognized:

- No ***"addictive personality"*** has been identified for cocaine or any other drug, including alcohol. Many mature, stable, well-functioning persons have become full-blown cocaine addicts although all started with occassional use. They never intended to become addicts or even considered themselves to be potential candidates for an addiction problem. Since we cannot predict in advance who among the total number of users will eventually become addicted, the only sure way to prevent this problem is to not use cocaine in the first place. Given what we now know about this drug, it appears that experimenting with cocaine is like playing "Russian Roulette" with your health and your life.
- Occassional users are more likely to escalate their intake of cocaine with increased access and availability of the drug and also during periods of high stress since the instantaneous euphoria and stress relief from cocaine becomes more appealing under stress. Perhaps this is why so many hard-driving successful people are among the ranks of severe cocaine abusers.

6. ***Intranasal use offers no guarantee of safety.*** Addiction and medical consequences are entirely possible with intranasal use. The majority of callers to 800-COCAINE are intranasal users as are the majority of people who seek treatment for cocaine problems. Coroners reports from at least several locations in the U.S. have documented cases of death from intranasal cocaine use.

7. ***Cocaine use promotes the use and abuse of other drugs.*** Alcohol and other drugs are often taken in excess by cocaine users to alleviate the unpleasant side effects (e.g., jitteryness, depression,

insomnia, irritability) that develop from chronic cocaine use. Many become dependent on alcohol, sleeping pills, tranquilizers, and even heroin as a direct result of involvement with cocaine.

3. NEW FINDINGS FROM THE HOTLINE: 1983 vs. 1985

More Widespread Use & Lower Prices. The cocaine epidemic has not yet reached its peak. Rather, it appears to be spreading to all geographic areas of the U.S., to all socioeconomic and ethnic groups, and to youngsters. Cocaine use is no longer restricted to the rich and famous or to the white upper class. With increased supplies and lower prices, cocaine has rapidly become the drug of choice among the middle class. The price of cocaine has fallen by at least 50% in the past year such that a gram of cocaine, at $65-75 on the illegal market, is now cheaper than an ounce of marijuana. This dramatic price drop has contributed to increased use by adolescents and by people in lower socioeconomic groups.

Profile Shifts. No longer is there a single demographic profile that is descriptive of most users; rather, cocaine users range from unemployed ghetto dwellers committing violent crimes for the drug-- to working people with ordinary jobs who deal cocaine to friends to support their habit-- to top-level business executives and professionals whose careers, comfortable lifestyles, and financial assets are destroyed by cocaine addiction. Cocaine problems have crossed all economic, social, and racial boundaries.

Use in Critical Jobs. One of the most disturbing developments is the increased use of cocaine by people in "critical" job positions where drug-related problems in work performance could lead to disastrous consequences. Such individuals include airline pilots, school bus drivers, nuclear power plant and defense personnel, fireman and police officers, prison guards, physicians and other health professionals, etc., who are represented among callers to the Helpline and patients who have entered our treatment programs.

Survey Results: 1983 vs. 1985. The Hotline data shown in Table 1 (next page) demonstrate a number of significant shifts in the patterns of cocaine use in the U.S. over the past two years. The most noteworthy changes include the following:

1. ***The cocaine epidemic has spread to the southern and midwestern regions of the U.S.*** The proportion of Hotline calls from these areas has increased significantly although the absolute numbers of calls remain greatest from the northeastern and western parts of the country. Cocaine use has spread to small towns and rural areas and it appears that the drug can be purchased almost anywhere in the U.S. We continue to receive Hotline calls from remote areas of the country

CD

2

0992

including small towns in Wyoming, Montana, Mississippi, New Mexico, Alaska, etc.

2. ***More women are using cocaine.*** In 1983, women represented about one-third of callers and now they represent nearly one-half. This can be attributed to lower prices, exposure to cocaine in the workplace, and introduction to the drug by male companions.

3. ***More minorities and lower-income groups are using cocaine.*** A greater percentage of callers earn less than $25,000 per year and an increasing number are Black and Hispanic. Lower prices of cocaine have undoubtedly contributed to this phenomenon.

4. ***More adolescents are using cocaine.*** In 1983, only 1% of callers were adolescents and now 7% are between the ages of 13 and 19. Increased use by adolescents and young adults (i.e., college students) probably accounts for the lower average age of hotline callers in 1985.

5. ***Levels of consumption have increased.*** Since 1983 there has been a shift among current users toward more intensified patterns of use. Average weekly consumption has increased and more users have switched to freebase smoking-- an especially toxic and dangerous way to use cocaine.

6. ***Polydrug abuse has increased.*** A greater percentage of hotline callers in 1985 report severe abuse of other drugs or alcohol in trying to alleviate the unpleasant side effects of cocaine. More callers are reporting addiction to these other substances.

7. ***Automobile accidents on cocaine have increased.*** In 1983, 11% of callers reported having had at least one cocaine-related auto accident. In 1985, this number increased to 19%. Because cocaine's powerful stimulant effects mask and postpone the depressant effects of alcohol, the cocaine user can consume a large quantity of alcohol and not feel too drunk to drive-- at least not at the beginning. Subsequently, when the cocaine effects wear off rapidly within 20-30 minutes, the intoxicating effects of alcohol may cause a sudden stuporous state or may cause the driver to fall unconscious without warning.

8. ***Cocaine use in the workplace has increased.*** The number of callers who say they use cocaine at work has increased sharply from 42% in 1983 to 74% in 1985. Many say that cocaine hinders their work performance and that the drug is readily available in their workplace setting.

Table 1

800-COCAINE HOTLINE SURVEYS

Each survey is based on a random sample of 500 callers during a three month time period: May-July 1983 and January-March 1985.

	1983	1985
Origin of call:		
Northeast	47%	32%
Midwest	11%	23%
West	33%	22%
South	9%	23%
Demographics:		
Males	67%	58%
Females	33%	42%
Whites	85%	64%
Black/Hisp	15%	36%
Average age	30 yr	27 yr
Adolescents	1%	7%
Yearly income:		
$0-25,000	60%	73%
over $25,000	40%	27%
Cocaine Use:		
Consumption	6.5 g/wk	7.2 g/wk
Expenditure	$637	$535
Intranasal	61%	52%
Freebase	21%	30%
Intravenous	18%	18%
Use of Other Drugs to alleviate unpleasant effects of cocaine:	68%	87%
Auto Accident on cocaine	11%	19%
Use of Cocaine at Work	42%	74%

4. CONSEQUENCES OF COCAINE USE

Cocaine use is associated with a wide range of physical, psychological, and social consequences as shown below by surveys of Hotline callers:

Physical & Psychological Consequences	
Sleep problems	82%
Chronic fatigue	76%
Severe headaches	60%
Nasal bleeding	58%
Depression	83%
Irritability	82%
Memory problems	57%
Loss of sex drive	53%
Brain seizure	14%
Attempted suicide	9%

Social Consequences	
Drug dealing	39%
Stealing	29%
Job problems	40%
Family/marital probs	66%
Loss of friends	51%
Financial problems	88%

5. TREATMENT SUCCESS RATES

Cocaine abuse is a treatable problem and success rates are good for motivated patients who want to be drug free. The greatest obstacle to treatment success is the continuing lure of cocaine's powerful euphoric effects coupled with easy access to the drug and social pressures to continue using it.

The treatment must focus on complete abstinence from cocaine and all other mood-altering drugs, including marijuana and alcohol. Treatment cannot be effective while the patient continues to use drugs. The majority of cocaine abusers can be treated as outpatients and do not need hospitalization. Neither substitute drugs nor a gradual withdrawal period are needed to stop using cocaine.

53-440 O - 86 - 4

At Regent and Fair Oaks Hospitals, we have developed specialized inpatient and outpatient treatment programs for cocaine abusers. Our success rates show that ***over 65% of the patients complete the 6-12 month outpatient program (either with or without prior hospitalization) and over 75% are still drug free at 1-2 year followup.*** These programs include a strong focus on complete abstinence, intensive drug education and peer-support groups, family meetings, mandatory urine tresting throughout the program to verify abstinence from drugs, and the use of specific recovery training and relapse prevention techniques to help patients cope with drug cravings and situations that may threaten their abstinence. Participation in self-help groups such as Cocaine Anonymous , Alcoholics Anonymous, and Narcotics Anonymous, is strongly encouraged.

6. RECOMMENDATIONS

The Federal government can help to combat the current cocaine epidemic and prevent more people from using the drug in a number of different ways, some of which are outlined below:

1. PUBLIC EDUCATION & MEDIA CAMPAIGNS. There is a pressing need for more public education about cocaine and other drugs. Our nation suffers from an overly accepting attitude about drugs and their potential dangers. The power of the media to assist in this effort has not been adequately tapped. The major goals of these efforts must be to change the public's attitude about drugs, decrease the social acceptance of drug use, and decrease the stigma associated with seeking help for drug problems. Possible strategies for better educating the public would include: creative and credible public service announcements on TV, radio, and the print media, produced with the help of drug abuse experts and professional advertising or PR firms; federally-funded regional conferences on cocaine and other drugs targeted to parent, school, community, and business groups with media used to announce the conferences and report the events that took place in an interesting and informative manner. Since the media is one of our most powerful tools for public education, the federal government could sponsor the formation of a drug abuse prevention council consisting of media experts and substance abuse experts to formulate and execute a comprehensive public education campaign.

2. SCHOOL-BASED PREVENTION PROGRAMS. Comprehensive substance abuse education and prevention programs in our nation's schools is absolutely essential. Following from the model of the NIAAA/NIDA-sponsored *"Student Assistance Program"* initiated in New York's Westchester County, every school district or county should have a

specialized program to prevent drug experimentation and to identify as early as possible substance-abusing youngsters in need of help. Efforts at drug abuse prevention in the schools must start well before high school since attitudes about drugs may already be solidified by that time, and recent evidence suggests that drug experimentation often starts in the 7th or 8th grades. At the very least, every school system should have a substance abuse advisory board to guide school policies on drug abuse and to provide the impetus for enacting prevention efforts.

3. **MANDATORY DRUG TESTING IN 'CRITICAL JOBS".** Being drug free must become a requirement for certain types of jobs where the health and welfare of others are at stake. Urine testing should be mandated in industries already regulated by the federal government (transportation, nuclear power plants, other utilities, etc.) and be considered for other types of "critical" jobs".

4. **MANDATORY DRUG TESTING IN DWI'S.** Not a single state in the U.S. currrently requires drug testing in cases of suspected driving while intoxicated (DWI)., although the contribution of drug use to automobnile accidents and fatalies is probably significant. All states should be encourage to include drug testing in their anti-DWI efforts. Similar to the seat-belt laws, states that fail to do DWI drug testing could be deprived of federal highway funds.

5. **TREATMENT & PREVENTION FUNDS.** State substance abuse agencies are in need of greater federal support to provide subsidized treatment for cocaine abusers who cannot afford private treatment. Few state-supported programs have specific treatment slots or specialized services for cocaine abusers. These patients are best treated in drug-free outpatient programs and not in methadone clinics. Staff training in the treatment of cocaine abuse is sorely needed in public programs.

6. **EDUCATION & TRAINING OF HEALTH PROFESSIONALS.** Although substance abuse is our nation's leading public health problem, specific training in the diagnosis and treatment of substance abuse disorders is not a standard feature of education in the health professions. Licensing requirements for physicians, psychologists, nurses, pharmacists, social workers, and other medical/mental health professionals should include this type of training.

7. **REDUCE FOREIGN AID TO COCAINE-PRODUCING COUNTRIES.** Many South American countries continue to supply our citizens with cocaine, on the one hand, while taking foreign aid money with the other. Monetary incentives to stop cocaine exportation must be considered more seriously.

PRESENTED TO THE UNITED STATES HOUSE OF REPRESENTATIVES, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL, WASHINGTON, D.C., JULY 16, 1985

COCAINE ABUSE 1985:

A MEDICAL AND PSYCHOLOGICAL NIGHTMARE

[Summary]

Cocaine abuse today is a national epidemic that encompasses all ages, economic and ethnic groups. This testimony focuses on the physiological effects of cocaine, the destructive nature of the drug, and the abuser's powerlessness over its highly addictive qualities.

It is estimated that over 20 million Americans have used cocaine at least once during the past four years. Cocaine has moved from 6th to 5th place among drugs most often mentioned in emergency room visits. There are ever-increasing reports by medical examiners of cocaine-related deaths.

Cocaine abuse in our nation will continue to increase unless the Federal Government develops more stringent policies to drastically reduce or eliminate the amount of cocaine imported into the United States from source countries.

Ronald J. Dougherty, M.D.
Administrative Service Chief
Benjamin Rush Center
Syracuse, New York 13202

ldg
7/1/85

Cocaine Abuse 1985: A Medical and Psychological Nightmare

Presented to the United States House of Representatives
Select Committee on Narcotics Abuse and Control
Washington, D.C., July 16, 1985

The Benjamin Rush Center Hospital in Syracuse, New York, includes a 32-bed Chemical Abuse Recovery Service (CARES) Unit. Four years ago, it was rare to admit even one cocaine abuser per month. At the present time, 40% of all admissions to the CARES Unit are for cocaine abuse. It is estimated that well over 20 million Americans have used cocaine at least once during the past four years, and that at least 5,000 persons per day use it for the very first time. A conservative estimate of the total number of cocaine addicts in this country now stands at 2 million.

One should not gain the impression that cocaine admissions to the CARES Unit are from the affluent, white collar set. Many cocaine referrals come from towns with as few as 200 people, and the Unit often treats cocaine-dependent persons who are from the middle class—tractor salesmen, dealers in farm equipment, and individuals who work at lumber mills in central and upper New York State.

In addition to the adverse consequences that occur as a result of its use, the frightening aspect of cocaine is that the price is dropping dramatically and the quality is improving. It is estimated that only 10% of the cocaine bound for the U.S. for illicit use is intercepted.

In addition to the conventional ways that cocaine comes into this country via boats and planes, human "mules" also strap this substance to various parts of their bodies with tape, carry it intravaginally, or as in the case of "body packers", carry it in the gastrointestinal tract. Many entrepreneurial drug smugglers manage to swallow as many as 50 to 150 condoms or balloons filled with cocaine. Once they reach their destination in the U.S., they use cathartics, enemas, etc. to pass the contraband; they are then able to proceed with their cocaine dealing. There are obvious risks in being a body packer. The greatest is that the condoms or balloons may act as semi-permeable membranes and occasionally water will enter these containers and cause them to explode within the G.I. tract. Another risk is that the cocaine will pass through the semi-permeable membrane into the G.I. tract and subsequently enter the bloodstream. The end result is death from cocaine overdose.

In one such instance, a medical examiner autopsied an individual who had well over 70 condoms double-wrapped within the G.I. tract; he had been found dead in a motel. In this particular instance, the cause of death was over-hydration (from tap water enemas as well as water ingested orally in an effort to eliminate the contraband from the body). This person had lowered his serum electrolytes and caused a cardiac arrhythmia death.

Cocaine is a powerful stimulant when used legally or illegally. Cocaine abusers talk about the "rush", which is usually over in a matter of five minutes, and the "high", which lasts approximately one-half to one hour. The route of administration of cocaine abusers varies as time goes on. The most recent 50 cocaine admissions indicated that 40% snorted cocaine, 30% used the freebase method, and 20% used it intravenously. The remaining 10% used a combination of the above, including one young lady who administered it rectally via an eyedropper. Lest one think that this is an unusual route of administration, it must be remembered that cocaine is absorbed through any mucous membrance, including nasal, oral, rectal or vaginal membrances.

Cocaine appears to be the "ideal" drug for the anorexic-bulimic patient. Five out of the first six female cocaine abusers admitted to the CARES Unit had a history of anorexia-bulimia. When a cocaine addict goes on a binge for two to three days, he or she does not eat; this provides the ideal method of losing weight plus getting the greatest rush or high available from any drug known to man at the present time.

Cocaine toxicity can occur regardless of the route of administration. Frequently, the cocaine toxicity is what actually brings a person in for medical treatment, rather than any great desire to stop using the drug. Cocaine can have an adverse effect on the mucous lining of any part of the body. In addition, it can adversely effect the sinuses, the trachea and the lungs. It is not uncommon for persons who are freebasers to present with complaints of severe respiratory compromise. It is felt that the side effects experienced with freebasing are as much due to the propane torch used to heat the cocaine as from the drug itself. The iris and the conjunctiva are irritated as a result of persons snorting cocaine via the nasal route of administration. Skin abscesses and cellulitis occur in individuals who are "skin poppers". After the veins are destroyed, these persons will begin injecting the drug directly into the skin and subcutaneous tissue.

In the CARES Unit, X-rays of the sinuses are taken on individuals who have a six-month or longer history of continuous cocaine snorting. Sinus X-rays of a 23 year old referred for cocaine abuse demonstrated a large abscess of the right maxillary sious. This is not at all uncommon. Three days after his admission, this young man sneezed; he saved the material, as it was unlike anything he had ever sneezed out before. This material was actually the remaining third of his nasal septum. Ear, nose and

drug or drugs (cross addiction). Of that 70%, 45% are also abusing alcohol; 15% also abuse marijuana; 20% also abuse alcohol and marijuana; and the remaining 20% also abuse alcohol in combination with other drugs. Often, the cocaine abuser will minimize the other drug or drugs of abuse. Only after pointing out to the alcohol-abusing cocaine patient that their liver is enlarged 3-4 fingerbreadths and their hepatic enzymes are greatly elevated will he realize that the 150-proof rum (which is being used in the freebase process as well as consumed orally) is causing serious medical complications. Cocaine abusers will often minimize their involvement of the other drugs mainly because those drugs are not the drugs that are causing great financial losses.

It has also been found that the average cocaine user whose drug habit exceeds $600 per week is also dealing the drug, regardless of his status in life. He obviously has to get into the dealing part in order to continue to afford his own drug. After awhile, however, the cocaine-abusing dealer becomes unwilling to share his drug, even after it has been adulterated. It is not uncommon for the individual who is a cocaine-abusing dealer to call a person to whom he has sold the drug within a few hours after the sale and offer to buy it back for his own consumption.

Blackouts have long been recognized as a common amnesic episode for the alcohol-addicted patient. The same phenomenon of blackouts in patients who are cocaine abusers may be observed. In one instance, a patient referred himself for treatment of his cocaine dependence because, during a cocaine blackout, he had severely beaten his 14 year old daughter and did not recall any of the events leading to the beating nor the actual event itself. Another patient who is a cocaine dealer as well as a user referred himself after he had gone on a three-day binge of cocaine basing with his friends and then went home and raped his eight-month pregnant wife; this caused her to go into premature labor with massive vaginal bleeding. He recalled none of these events.

Craving is a common phenomenon during the abuse of cocaine and is especially intense during the first six months after ceasing its use. Craving can be triggered by seeing a person with whom one has abused cocaine in the past, by hearing a familiar song that was heard during the cocaine-abusing period, or seeing a house or neighborhood in which a person had previously abused cocaine. These factors can immediately trigger off intense craving, palpitations and sweating. Paranoia of the ill-defined and the defined varieties is quite common during cocaine abuse as well as during the initial period of abstinence. The person will suddenly develop an intense paranoid state without provocation. Patients and their families have to be reassured that this is a self-limiting phenomenon and that it will lessen with the passage of time; it will not respond to use of antidepressant medication.

Visual and auditory hallucinations are common for the cocaine abuser. Peripheral blue lights, seen out of the lateral aspects of the field of vision, are frequently reported. Also frequently noted are the tactile hallucinations of "bug bites". The sensation that the skin is crawling with bugs is also seen in patients who abuse Talwin and Pyribenzamine. It is the author's belief that this is related to the adulterants added to the cocaine, rather than to the cocaine itself.

Weight loss is common for the cocaine abuser. A patient was recently admitted who had lost a total of 50 lb. in the six months prior to treatment. Personal hygiene frequently deteriorates for the cocaine abuser. A stockbroker referred to us by his peers had not taken a bath for the two weeks before entering our program, and he had continued to wear his three-piece suit to work every day during this period. Cocaine abusers are simply too busy, in many instances, to even take time out to go to the bathroom. One patient rationalized that he could urinate into his clothes and take a shower later. Persons who are preoccupied with freebasing may take a total of two hours to complete the morning ritual of going to the bathroom, washing, shaving and getting dressed; they will stop to freebase several times during the process.

It is extremely important that patients who have completed their program of inpatient treatment and who are participating in NA and/or AA on a regular basis receive reassurance that the overwhelming cocaine craving they experience is not abnormal and that this will lessen with time, though it may never completely disappear. During their recovery, cocaine abusers also will develop "dry highs" very much analogous to the alcoholic who has "dry drunks". It is thought that the reason for these phenomena are that dopamine and norepinephrine are depressed during the abstinent phase. The production of these substances is not steady and may occur in an erratic fashion. This may account for the distressing symptoms which occur during recovery. There are studies in progress that appear to indicate that persons who continue to abuse cocaine chronically develop permanent suppression of these substances; one cannot distinguish them from schizophrenic patients. It is hoped that with regular utilization of support systems (such as NA and AA) and family education regarding the cocaine abstinence phenomena, the recovering cocaine abuser will become able to deal with and overcome the abstinence syndrome.

I have been asked whether we can eliminate cocaine abuse. I doubt this for several reasons. Certainly, cocaine is not a new drug; it has been used in the U.S. for over 100 years. Another factor is that there are problems with our judicial system. In my opinion, there are judges who are too lenient in establishing bail. In one case I am aware of, a judge on the East Coast set bail at $200,000 each for 22 cocaine dealers. With no difficulty, each defendant met bail quickly, in cash, and all were last seen boarding a plane for Bogata, Columbia. I feel that, in order to ensure that cocaine dealers do not jump bail, significantly higher dollar amounts must be set. If dealers do skip the country, the several millions of dollars in cash or real property taken from them could be used in efforts to prevent and/or treat cocaine addiction.

It has been estimated that only 10% of the cocaine coming into this country is actually intercepted in the process. There have been several episodes in which two tons of Columbian cocaine, amounting

to over $1 billion in street value, have been confiscated. Obviously, greater national/international law enforcement efforts are needed to increase the confiscation of U.S.-bound cocaine. It would appear to me that since cocaine is the eighth largest industry in the United States, the Federal Government should take a long, hard look at whether we should continue to aid those countries who are major cocaine producers. These counties are accepting U.S. dollars with one hand while they are pushing cocaine into the noses, arms and lungs of the American people with the other.

It was only after the U.S. was able to convince Turkey during the late 1960s and early 1970s that all financial aid to that country would stop unless production of opium ceased, that production of the opium poppy intended for the illicit production of heroin finally stopped. Unless the U.S. government can get this message across to the governments of Peru, Bolivia and Columbia, it is very unlikely that the cocaine traffic will cease.

There is no simple answer to the cocaine problem. It will require the continued efforts of those of us in the prevention, education and treatment fields, but there must also be serious efforts by law enforcement officials, the courts and the governments of both the United States and the South American nations where cocaine is grown and processed to stop the nightmare of cocaine.

Ronald J. Dougherty, M.D.
Administrative Service Chief
Benjamin Rush Center CARES Unit
Syracuse, New York 13202

Medical Director, Pelion, Inc.
Outpatient Substance Abuse Program
Syracuse, New York 13202

Dr. Ronald J. Dougherty

Dr. Dougherty is Service Chief of the Chemical Abuse Recovery Service at the Benjamin Rush Center in Syracuse, New York. He also acts as Medical Director for the Pelion Prescription Drug Misuse Program and Chronic Pain Rehabilitation Program, also in Syracuse, New York. In addition, he has a private office (family practice) in Brewerton, New York where he resides.

While president of the staff of St.Mary's Hospital in Syracuse in 1970, Dr. Dougherty began the inpatient detoxification of drug abusers in response to a community lack of hospital beds specific to that purpose. In February of 1971, he officially opened and directed at St. Mary's Hospital the first inpatient drug detoxification unit in Central New York. This was followed shortly thereafter by the addition of an outpatient clinic for evaluation and treatment of patients whose problems with prescription, as well as illicit, drug abuse needed to be addressed. He subsequently added a chronic pain clinic component to the outpatient drug abuse program to address the problems of chronic pain present in many prescription drug abusers.

Dr. Dougherty has gained national recognition for his expertise in the fields of substance abuse and management of chronic pain. He was awarded the Distinguished Service Award by the Onondaga County Medical Society for his work in the drug abuse field: "for his outstanding and untiring efforts toward the solution of the drug problem in Onondaga County as director of the Detoxification Unit of St. Mary's Hospital, Syracuse, New York, and for his statewide contribution as Chairman of the Drug Abuse Committee of the New York State Academy of Family Practice, the Onondaga County Medical Society, in recognition of Dr. Ronald J. Dougherty's talents, confers its Distinguished Service Award as a mark of the esteem in which he is held by his professional colleagues."

On June 4, 1983, Dr. Dougherty received the "Distinguished Alumni Award" from LeMoyne College "for his involvement with our nation's medical and social problems". More recently, on October 25, 1983, Dr. Dougherty received a Special Service Award from the Urban Coalition as a distinguished contributor in the field of substance abuse. On September 28, 1984 Dr. Dougherty had the privilege of being asked to speak by the United States House Of Reparesentatives to the Black Caucus. The presentation was entitled "Drugs: Effects on the Black Community". The highlight thus far in 1985 has been his appearance on the CBS Morning News on March 1 in which he was interviewed by Phyllis George on the subject of Women and Cocaine.

In each year, 1982, 1983, and 1984, Dr. Dougherty gave over 80 talks and presentations throughout New York State as well as in other states throughout the country. He had several articles and papers published on the subjects of substance abuse and chronic pain. His most recent publication entitled "Status of Cocaine: 1984" was published in the first issue of the Journal of Substance Abuse Treatment for which he is now on the editorial board. Also in 1985, Dr. Dougherty was interviewed by the New York Times for a feature story on "Women and Cocaine". He addressed medically oriented groups, including physicians, nurses and medical students, as well as industry, community service organizations, schools, churches and synagogues. Dr. Dougherty felt that the highlight of his speaking engagements was in 1982 when he had the opportunity to address his peers in San Francisco at the annual scientific exhibition of the American Academy of Family Physicians. His presentation, entitled "Drug Abuse in the 80's", was well received by 2,000 physicians.

The January 1983 issue of Syracuse Magazine listed Dr. Dougherty as one of the "people to watch in 1983". The article stated that "in 20 years of medical practice, dealing with drug abusers and alcoholics, Dr. Ronald J. Dougherty has seen enough cases to convince him of the connection between chronic pain and substance abuse. And, in response to what he saw as a special need for these patients, he began Pelion, Inc., a program for prescription drug abusers that treats the individual, not just the disease, and focuses on drug-free rehabilitation.

Dr. Dougherty is currently the chairman of the Committee on Drug Abuse of the New York State Medical Society and serves on the Govenor's Advisory Council on Drug Abuse, the New York State Division of Substance Abuse Services Committee on Prescription Drug Abuse and the New York State Health Department Substance Abuse Committee. In June 1983 he was appointed as a member of the Citizen's Alliance to Prevent Drug Abuse through the New York State Division of Substance Abuse Services. In 1984, he was appointed as one of three co-directors of the Impaired Physicians Program of the New York State Medical Society. He is also on the Board of Professional Medical Conduct. Also in the recent past he has been appointed to be member of the American Medical Association's Council on Scientific Affairs on the subject of Thermography. Most recently on June 1985 he was selected for the Governor's Advisory Council on Substance Abuse. He is past president and current member of the Board of Directors of Syracuse Brick House, Inc. He was also an invited member and contributor to the White House Conference on Prescription Drug Abuse and Misuse, in the fall of 1980.

WRITTEN TESTIMONY

HOUSE SELECT COMMITTEE ON NARCOTICS

JULY 16, 1985

RICHARD L. HAMILTON
DIRECTOR DRUG ABUSE ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
STATE OF MARYLAND

At the present time it is estimated that more than 20 million Americans have tried cocaine with a total cost of between $50-$70 billion. Many people, misled by the failure of cocaine to satisfy the classical definition of an addictive drug, have experimented with what they thought was a benign drug. For some, this experiment has turned into personal tragedies including overdoses and suicide. Dr. Charles Schuster of the University of Chicago claims that the narrowness of the classical definition of "addiction" has deceived a generation of Americans about cocaine and is one of the reasons so many people have become hooked. He states that "if addiction means increased dependence, with an increased compulsion for heavy users to spend disproportionate amounts of time seeking, thinking and indulging in the drug, then cocaine is addictive". Information from the Drug Abuse Warning Network (DAWN) measuring cocaine incidences in hospital emergency rooms indicates that the United States is experiencing an unprecedented increase in adverse health consequences from cocaine abuse.

Before anyone can understand and fully comprehend the cause and effect of one of the most serious epidemics this country has ever known, it is necessary to know the kind of people that are involved. Dr. Denise Kandel of Columbia University recently found in a longitudinal study of 1325 young adults that cocaine abusers most likely are unmarried, have unstable work and marital histories, have been involved in auto accidents while drunk or stoned, have

been arrested by the police, and have suffered psychiatric problems. Dr. Mark Gold reports that from the Cocaine Hot Line 42% reported they stole from their family and friends to support their habit. Dr. Herbert Kleber reported treating an engineer who sold cocaine, clearing $2,500 per week to supplement his $500 a week salary to support his habit. Dr. Sid Schnoll from Chicago described 172 patients as mostly affluent with occupations ranging from commodity and stock brokers to unskilled blue-collar workers and more than 60% had attended college. These data forces to accept that there is no one group to corral; this drug pervades all classes of society. At one time not too long ago, it seemed that perhaps the poor were safe but with the price of cocaine decreasing over the past year to eighteen months by as much as 50% even the poor can now afford to get high, get sick, get addicted to what I believe to be the most damaging drug to invade our society. It's this invasion of all segments of our community, our nation; this seduction of a generation and the lasting effects over the next decade that leads me to believe that by every and any definition of the word, we are experiencing the birth pangs of an epedemic. Birth is occurring and the baby is rapidly becoming the beast.

Now for some facts and figures; first from around the country from a few selected cities and then back to Maryland specifics.

In April 1984 Boston for the first time reported the cocaine emergency room episodes equalled heroin episodes. In Boston street cocaine is 38% pure and the price is down to $100/gram.

In New York between 1982 and 1983 cocaine involved emergency room episodes increased 42%. Cocaine purity was as high as 40%. Treatment admissions with cocaine abuse as the primary drug accounted for 13% of all admissions, the highest ever.

In Miami, cocaine is the most prevalent drug costing only $40-60 per gram. Over the past three years emergency room mentions for cocaine have risen dramatically from 252 in '81 to 408 in '82 to 548 in 1983. Seventy per cent of everyone admitted to treatment during the first four months of '84 were using cocaine and one-third of these were intravenous users.

In 1984, the number of treatment admissions in Dallas that reported cocaine as their primary drug of abuse was double the number admitted in 1982. The lowest recorded purity of the cocaine exhibits in Dallas was about 30% and typically ranged between 50 and 60 percent. In New Orleans, cocaine continues to be readily available in large quantites. Ounce purchases during July to December 1983 ranged from $1,600 (65% pure) to $2,800 (70% pure). Several indicators in Detroit showed elevated levels of cocaine use. Cocaine arrests increased 20% over 1982 and approximately twice as much cocaine (six pounds) was seized in 1983 as compared to 1982. Chicago reports an abundant supply of cocaine with a significant increase in the purity as well as corresponding reductions in the price at the wholesale level. Yearly admissions to treatment for primary cocaine use in Denver have increased to their highest percentage to date--from 21.5% to 24.0%. In Minneapolis the purity of the cocaine was reported at 14.5 to 100 percent with an average purity of 30 to 39 percent and a slightly decreased retail price from between $110 and $120 per gram to between $100 and $110 per gram. During the first five months of 1984, a total of 82 cocaine seizures resulted in close to 950 grams being seized.

Cocaine in St. Louis is widely available at $80 to $110 per gram. Clients admitted to treatment who reported cocaine as their primary drug of abuse increased by 366% between 1982 and 1983. A kilogram of 90% pure cocaine sold in Phoenix for $40,000 to $60,000 in 1983. The price has continued to decline during the first part of 1984.

In Seattle, cocaine use continues to be the most important drug problem. DAWN emergency room data indicate a pattern of consistent increases without signs of abatement. Seizures of this substance have increased dramatically. However, the price of gram units has remained constant at $100 to $150 with a purity level of about 20 percent. DAWN data for San Francisco show an 80% increase in emergency room episodes from 1982-83 to the first quarter of 1984 and the Coroner reports a sharp increase in the number of cocaine-related deaths. Increases in the street quality of cocaine have been noted while quoted prices continued their steady fall from $115 in early 1982 to $107 in the most recent period. As the third major drug of abuse in Los Angeles, cocaine has shown increases in emergency room mentions, deaths, treatment admissions, and seizures. Cocaine abuse emergencies have increased at amore proprotional rate for women than for men. A similar trend has been noted for women in cocaine death raports. Cocaine, which is plentiful in San Diego, has experienced a sharp decrease in street price--between $75 and $80 per gram. Twenty-five percent of all 1983 admissions were for cocaine and ER episodes increased 18% during the past six months, compared to the previous six months.

But allow me to relate to you the situation in Maryland.

First, cocaine is plentiful in Maryland. The Baltimore City Police tell us that what sold on the streets during the summer of '83 for $85 is selling for $15-$20 in the summer of '85. And the purity is 40-60%.

During 1980 there were 307 occurrences of cocaine as a primary problem (2.8% of all admissions). By 1983, this had risen to 819 occurrences (a 167% increase), constituting 6.7% of admissions. The number of cocaine primary problem admissions during the first eight months of 1984 was 943 (10.2% of admissions), exceeding the full-year 1983 figure of 819. In 1984, 1,415 clients were admitted with primary problems of cocaine during 1984, a 73%

increase over 1983 and a 360% increase since 1980. The year-to-year increases in cocaine primary problem admissions are as follows: 19.9% in 1981; 49.7% in 1982; 48.6% in 1983; and, 73% in 1984.

Cocaine has also increased significantly as a secondary drug problem. About 20% of FY 1984 admissions reported cocaine as a secondary problem, including 38% of admissions reporting cocaine secondarily. Cocaine has become by far the leading choice of secondary drug by heroin abusers, and is second only to alcohol as most popular secondary drug overall. The year-to-year increases in secondary cocaine problem admissions are as follows: 9% in 1981; 52.5% in 1982, 30.4% in 1983; and 50% for 1984. For the entire period the increase is projected to be 260.1%.

During 1980, there were 1,391 total cocaine mentions among the admissions to drug abuse treatment. By 1983, this figure had undergone a 111% increase to 2,941. 1984 recorded 4,703 cocaine mentions, a 60% increase over the 1983 total and a 238% increase over the 1980 total.

So much for total numbers. Let's look for a moment at sex, race and age.

In each year, white males have been the largest race/sex category of primary cocaine admissions, although they reach their lowest percentage in 1984 (45.9%) and black males reach their highest (37.8%). Whereas white males increased 60.1% from 1983 to 1984, black males increased by 114%. The ratio of white males to black males among primary cocaine admissions has gone from 2.21 to 1 in 1982 to 1.60 to 1 in 1983 and to 1.22 to 1 in 1984. The percentage of females among primary cocaine admissions has been decreasing since 1981, although the raw numbers have increased. There is some tendency for more recent primary cocaine admissions to come from older age groups, although this is probably due to the increasing proportion of black male abusers. In 1984, 16.2% of the white male cocaine admissions were over 30 while 27.3% of the black males were in that age group.

In terms of total cocaine mentions, black males predominate, accounting for 48.2% of the cases in 1984 compared with 30.1% consisting of white males. This is largely a reflection of the frequency of mention of cocaine as an accompanying drug problem with heroin in the primary slot. Although every sex/race group has shown substantial increases in cocaine mentions since 1980, the increases in blacks relative to whites has been larger. The ratio of blacks to whites has gone from .94 to 1 in 1981 to 1.14 to 1 in 1982 to 1.23 to 1 in 1983 and to 1.56 to 1 in 1984. Black admissions with cocaine mentions tend to be significantly older than whites, and an increase in the percentage of cases in the upper age groups can be seen in each year. Whereas 21.3% of cocaine mentions were over 30 in 1980 and 18.7% were under 21, 30.9% were over 30 in 1984 and only 14.4% were under 21. The ratio of male to female admissions with cocaine mentions was 3.7 to 1 in 1984, and this has not changed significantly during the 4 years and 8 months period.

As to employment status.

It is clear that cocaine admissions have a greater tendency than others to be employed, although this is becoming less and less evident with each succeeding year. While the precentages of both the cocaine group and the "other drugs" group who were employed among 18 and over cases have droppped each year, the employment rate of the cocaine group has dropped further. In 1980, 59.2% of 18 and over admissions with primary problems of cocaine were employed full or part-time, while the corresponding percentage for other drug categories was 43.3%. In 1981, the employment rate of primary cocaine admissions went to 57.6, in 1982 to 51.2, in 1983 to 43.0 and to 36.4% in the first eight months of 1984. Correspondingly, the percentage for other drugs fell to 42.6 in 1981, 36.3 in 1982, 35.4 in 1983 and 32.6% in 1984.

And finally let's look at the clients.

As expected, there is a tendency for primary cocaine admissions to have attained higher educational levels than admissions with other primary problems; however, there is some evidence that this pattern is changing. While the percentage of high school graduates among the 18 and over cocaine admissions has been in the 40-45% range during all 5 years, the percentage of clients who went beyond high school, which exceeded 20% in each prior year, fell to 15% in 1984. In the first eight months of 1984, admissions of 18 and over primary cocaine cases with less than a high school diploma or GED constitute 41.7% of these admissions, the highest such percentage during the 4 year 8 month period.

The data have shown an alarming increase in cocaine cases since 1980, with the most rapid changes occurring in the last twelve months of reported data. Cocaine's popularity is skyrocketing not only as a drug of first choice but also as a partner with heroin, marijuana, alcohol and PCP. Especially noteworthy is the frequency of cocaine abuse among clients with presenting problems of heroin. Evidence indicates that cocaine is becoming available to a wider portion of the population. More recent cocaine admissions tend to reflect a larger proportion of blacks, older, unemployed and less educated clients. Unfortunately, these data reveal no signs that the problem has or is about to peak.

RLH:fwm
7/16/85

Select Committee Staff Summary of Statement of James O. Mason, Acting Assistant Secretary for Health, Department of Health and Human Services

The most recent surveys by NIDA indicate that the number of new cocaine users has begun to level off, at least among those under 26, and young people are reporting increased awareness of the negative consequences associated with the drug. The statement notes heavier use among certain subgroups of cocaine users in the greatly increased demand for treatment of dependence and numbers of medical emergencies associated with cocaine use.

The NIDA National Household Survey shows that the number of people trying cocaine at least once (lifetime prevalence) increased from 5.4 million in 1974 to 21.6 million in 1982. The number of current users (any use in the past 30 days) of cocaine increased from 1.6 million in 1977 to 4.3 million in 1979 and remained stable at about 4.2 million in 1982.

HHS notes that cocaine abuse is found in all income groups. The High School Senior Survey for 1984 showed a "significant increase in 'current' cocaine use; 5.8 of the senior class using cocaine at least once 30 days prior to the survey."

Concerning the health consequences of cocaine use, the statement notes the impact of the dramatic increases in cocaine use in the late 70's is becoming more and more visable in terms of the demand for treatment of dependence and medical crises associated with cocaine use. A slight increase in the percentage of females reporting to emergency rooms for cocaine problems is pointed out, and that females using cocaine tend to be younger than male users.

The HHS statement says that although the 1982 survey data provide some evidence of new use among the population ages 26 and older, there is no evidence of significantly increased levels of new use of cocaine in the general population. HHS attempts to explain the large demand for cocaine treatment services to a "time lag" between the onset of cocaine use, and entry into treatment. The increased demand for treatment may also be explained by more frequent use by a subset of the cocaine-using population, and more dangerous methods of administration.

The manifestations of cocaine withdrawal are more like signs and symptoms of depression than the more obvious distress seen after withdrawal from opiates or sedatives.

The drug produces a number of markedly negative effects; including weight loss, increased heart rate and blood pressure, depression, irritability, anxiety, paranoia, and hallucinations.

Concerning the Federal role in combatting cocaine abuse, the statement notes that NIDA is devoting an increasing proporation of its resources to research aimed at understanding exactly how cocaine works, what its effects are, and what treatment and prevention approaches are most efficacious in dealing with this particular drug. In 1984, NIDA funded 23 grants relating to cocaine and other stimulants.

In 1984, NIDA also distributed a new research announcement to the field inviting applications for studies to broaden understanding of cocaine use and help identify effective strategies for treatment and prevention. NIDA is also developing a network for disseminating cocaine prevention materials and techniques through a wide range of public and private sector agencies. NIDA has recently signed a contract with the Advertising Council for a nationwide cocaine prevention media campaign, planned for early 1986.

BIOGRAPHICAL INFORMATION

James O. Mason, M.D., Dr.P.H.

Born and raised in Salt Lake City, Dr. Mason obtained his medical degree from the University of Utah College of Medicine. In 1958 he interned at Johns Hopkins Hospital in Baltimore, Maryland, and served his residency in Internal Medicine at Peter Bent Brigham Hospital, in Boston, Massachusetts. He has both a Masters degree and Doctor of Public Health degree from Harvard School of Public Health and is board-certified in General Preventive Medicine. Dr. Mason's medical career has included being Chief of the Centers for Disease Control's Epidemiologic Intelligence Service, Hepatitis Surveillance Unit and Surveillance Section. In 1964 he was Deputy Director of the Bureau of Laboratories at CDC and in 1969 became a Deputy Director of the CDC. From 1971 to 1979 Dr. Mason was the Commissioner of Health Services of the Health Services Corporation of the Church of Jesus Christ of Latter-day Saints and in 1979 became the Executive Director of the Utah Department of Public Health. Since 1983 he has served as Director for the Centers for Disease Control in Atlanta, Georgia. He also currently serves as the Acting Assistant Secretary of Health for the U.S. Department of Health.

Dr. Mason has been instrumental in establishing the Thrasher Research Fund and is currently serving as chairman of its Technical Advisory Committee and is a member of the Fund's Executive Committee.

CURRICULUM VITAE

Donald Ian Macdonald, M.D.
Administrator
Alcohol, Drug Abuse, and Mental Health Administration
5600 Fishers Lane
Rockville, Maryland 20857

Professional Positions:

1962 - 1984 - General Pediatric Practice, 1510 Barry Street, Suite C, Clearwater, Florida 33516

1980 - 1984 - Clinical Associate Professor of Pediatrics, College of Medicine, University of South Florida, Tampa, Florida

Education:

Undergraduate - Williams College, Williamstown, Massachusetts, B.A., 1952

Graduate - Temple University School of Medicine, Philadelphia, Pennsylvania, M.D., 1958

Internship - Duval Medical Center, Jacksonville, Florida, 1958 - 1959

Residency - Resident of Pediatrics, St. Christopher's Hospital for Children, Philadelphia, Pennsylvania, 1959 - 1962 (Chief Resident, 1961 - 1962)

Certified:

American Board of Pediatrics, 1963

Fellow:

American Academy of Pediatrics, 1963 - Present

Professional Activities:

1980 - Present - Drug Abuse Committee of the Florida Medical Association (Chairman 1983 - Present)

1981 - Present - Scientific Advisory Committee, American Council for Drug Education (formerly ACM), New York, New York (President 1981 - Pres)

1980 - 1982 - Director of Clinical Research, Straight, Inc., (Adolescent Drug Treatment Program) St. Petersburg, Florida

z

1970 - 1980 - School Health Medical Advisory Committee of the Florida Medical Association (Chairman 1975 - 1977)

1970 - 1980 - School Health Medical Advisory Committee of the Pinellas County Medical Society (Chairman 1970 - 1980)

1979 - Program Committee - Annual Meeting, Florida Medical Association (Nutrition)

1975 - 1979 - Nutritional consultant and lecturer, Florida Citrus Commission

1974 - 1976 - Commictee on School Nutrition, Florida Medical Association (Chairman 1974 - 1976)

1978 - 1983 - Consultant to Family Procection Team (Child Abuse), Children's Medical Services, St. Petersburg, Florida

1962 - Present - Numerous committees, Morton F. Plant Hospital, Clearwater, Florida (Chairman Department of Pediacrics 1965 - 1966, 1970 - 1971, 1975 - 1976)

Advisory Committees:

National:

1981 - 1983 - Board of Directors, National Federation of Parents for Drug Free Youth, Silver Spring, MD

Community:

1975 - Present - Junior League of Clearwater, FL
1982 - Present - Time-Out Homes (Child Abuse), Clearwater, FL
1980 - 1983 - St. Petersburg Junior College School of Nursing, St. Petersburg, FL
1976 - 1979 - Chairman, District VIII Advisory Committee, Health and Rehabilitative Services, State of Florida
1965 - 1978 - Childbirth and Parent Education League of Pinellas County, Clearwater, FL
1970 - 1976 - Library Board, Clearwater Public Library, Clearwater, FL
1965 - 1975 - LaLeche League of Clearwater, FL
1964 - 1967 - Board of Directors, Play Parc (Retarded children), Clearwacer, FL

Community Honors and Awards:

1983 - Outstanding Service Award, PAR Inc., Pinellas Park,FL
1982 - Honorary Lieutenant Colonel Aide-de-Camp, State of Alabama
1981 - Outstanding Community Service, Clearwater Junior Women's Club, Clearwater, FL
1969 - Outstanding Professional Service Award - Upper Pinellas Association for Retarded Children, Clearwater, FL

Professional Organizations:

Florida Chapter of the American Academy of Pediatrics and Pediatric Society (President 1982-84); American Medical Association; Florida Medical Association; Pinellas County Medical Society; Suncoast Pediatric Confereoce (Chairman 1975-80); Board of Governors, American Red Cross

Personal:

Birth: April 15, 1931; New York, N.Y.
Family: Married, 4 children

Publications

1. Macdonald, D.I.: School lunch, its past, its problems, its promise. Journal of the Florida Medical Association, May 1979.
2. Barness, Coble, Macdonald, Christakis, Editors: Nutrition and Medical Practice. AVI Publishing, Westport, CT, 1981.
3. Macdonald, D.I. and Newton, M.: The clinical syndrome of adolescent drug abuse. Advances in Pediatrics, Vol. 28 (1981).
4. Macdonald, D.I.: Urine Screen for cannabinoids, a Pediatric view in Urine Testing for Marijuana use, Implications for a Variety of Settings. American Council on Drug Education, New York, NY, p. 36, (1981).
5. Macdonald, D.I.: Health and educational effects of marijuana on youth. Hearing before Subcommittee on Alcoholism and Drug Abuse of the Committee on Labor and Human Resources, U.S. Senate, October 21, pp 75-80, 95-100 (1981).
6. Macdonald, D.I.: The relationship of moderate marijuana use and adolescent behavior. In Marijuana & Youth - Clinical Observations on Motivation & Learning. NIDA, U.S. Department of Health and Human Services, pp 45-60 (1982).
7. Macdonald, D.I.: Let's Not Legalize Marijuana: Letter to J. Clyde Ralph, Practical Pediatrics in Pediatric News, New York, March 1983.
8. Cupoli, J.M., Macdonald, D.I., Pitisci, G.J.: Changing life styles: Their effects on children, families and pediatricians. The Journal of Pediatrics, Vol. 102:6, 963 (1983).
9. Cupoli, J.M., Macdonald, D.I.: Editors. Proceedings of the Seventh Annual Suncoast Pediatric Conference, Clearwater Beach, FL, June 20-23, 1982 in the Journal of Pediatrics, Vol. 102:6, pp 963-1012 (1983).
10. Macdonald, D.I.: Comments in Adolescent Substance Abuse. Fourteenth Ross Roundtable on Critical Approaches to Common Pediatric Problems. Litt, I.F. (ed). Ross Laboratories, Columbus, OH (1983).
11. Macdonald, D.I.: The effects of alcohol and marijuana on the developing fetus. Int. Correspondence Soc. of Ob/Gyn Letters Inc., Lakeland, FL, Vol. 24:19 p 148, (1983).
12. Macdonald, D.I.: A boycott of Squibb. NY State Journal of Medicine Vol. 83:11-12, p 1151 (1983).
13. Macdonald, D.I.: Drugs, drinking and adolescence. American Journal Diseases of Children, Vol. 138:2, Chicago, IL (1984).
14. Macdonald, D.I.: Drugs, Drinking, and Adolescents. Year Book Medical Publishers, Chicago, IL (1984).
15. Macdonald, D.I.: FMA's fight against alcohol and drug abuse. Journal of the Florida Medical Association, Vol. 71:4 213-214 (1984).

CURRICULUM VITAE

MARVIN SNYDER, Ph.D.

DATE OF BIRTH: October 14, 1940

PLACE OF BIRTH: Brooklyn, New York

MARITAL STATUS: Married June 23, 1963, Arlyne

CHILDREN: Daughter, Sian

HOME ADDRESS: 1696 Dunstable Green
Annapolis, Maryland 21401

TELEPHONE: HOME: 301/849-5516, OFFICE: 301/443-1887

EDUCATION:

Degree	Year	School	Field
B.A.	1962	Brooklyn College	Psychology
Ph.D.	1967	Duke University	Biological Psychology

CURRENT POSITION: Director, Division of Preclinical Research, National Institute on Drug Abuse.

SOCIETIES AND HONORS:

Memorial Award for Outstanding Psychology Major, Brooklyn College, 1962.
Sigma Xi, Associate Member, Brooklyn College, 1962.
New York State Regents College Scholarship, 1958-1962.
Sigma Xi, Duke University, 1967.
American Society for the Advancement of Science.
Who's Who in America, 1982.
Who's Who in the East, 1983.
American College of Neuropharmacology.

RESEARCH EXPERIENCE:

1971-1972 Research Scientist, National Eye Institute, Section on Visual Physiology.

1967-1971 Staff Fellow, National Institute of Mental Health, Section on Neuropsychology.

1966-1967 USPHS Predoctoral Trainee, Duke University.

1965-1966 USPHS Predoctoral Fellow, Duke University.

1962-1965 NDEA Fellow in Biological Psychology, Duke University.

TEACHING EXPERIENCE:

1961-1962 Teaching Assistant, Brooklyn College, Department of Psychology.

1970-1971 Assistant Professor, Neuropsychology, National Institutes of Health Graduate School.

ADMINISTRATIVE EXPERIENCE:

1983-Present Director, Division of Preclinical Research, National Institute on Drug Abuse, Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA).

1979-1982 Director, Division of Research, National Institute on Drug Abuse, ADAMHA.

1977-1979 Special Assistant for Research Planning and Evaluation, Office of the Director, Division of Research, National Institute on Drug Abuse.

1974-1976 Research Psychologist, Neuroscience Program, Division of Research, National Institute on Drug Abuse.

SPECIAL FUNCTIONS:

1985-Present Executive Secretary, Interagency Committee on Pain and Analgesia. Chairperson, Subcommittee on Education and Training Issues.

1983-1985 Member, Public Health Service Executive Committee on Acquired Immune Deficiency Syndrome (AIDS).

1982-Present Member, Department of Health and Human Services Orphan Products Board.

1982-1983 Member, White House Task Force on Drug Abuse Health Issues.

1979-1984 Directed federal efforts to develop the drug naltrexone for the treatment of opiate addiction.

1979-1982 Co-Chairperson, Interagency Committee on Smoking and Health.

1978-1980 Member, Interagency Committee on New Therapies for Pain and Discomfort.

STATEMENT OF

JAMES O. MASON, M.D.
ACTING ASSISTANT SECRETARY OF HEALTH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SELECT COMMITTEE ON NARCOTICS
U.S. HOUSE OF REPRESENTATIVES

ON

COCAINE USE: ITS HEALTH CONSEQUENCES AND THE FEDERAL RESPONSE

JULY 16, 1985

Mr. Chairman and Members of the Select Committee:

Thank you for giving us the opportunity to discuss the consequences of cocaine use and the steps we are taking at the Department of Health and Human Services to deal with this major public health problem. I am accompanied today by Dr. Donald Ian Macdonald, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration and by Dr. Marvin Snyder of the National Institute on Drug Abuse.

Some Historical Perspective

I would like to begin by providing a little historical perspective. The use of cocaine is not a new phenomenon. Its use was widespread in the late 19th and early 20th centuries when it was an ingredient in many patent medicines, tonics, and soft drinks . Between the 1930's and the late 1960's, cocaine all but disappeared from the American scene. This downturn in cocaine use was probably due to a number of factors, including the Depression and restrictions on the importation, manufacture and distribution of cocaine.

As recently as the early 1970's, cocaine use was not a major problem. In 1973, the second report from the National Commission on Marijuana and Drug Abuse stated that, on the basis of available data, they could verify little social cost related to cocaine use in this country. At the same time, the report of the Strategy Council on Drug Abuse said that morbidity associated with current patterns of cocaine use did not appear to be great. The

document further stated that, at that time, there were virtually no confirmed cocaine overdose deaths and that a negligible number of individuals were seeking medical help or entering drug treatment programs for problems caused by cocaine use.

Unfortunately, these low rates of actual abuse may have led the public to conclude that cocaine was a safe drug. On the other hand, many drug experts and a number of government publications were stating--for those who wanted to listen--that cocaine use could have serious negative consequences and that, under conditions of greater accessibility, much more serious patterns of cocaine abuse would become evident. For example, the 1975 White Paper on Drug Abuse, prepared for the President by the Domestic Council Drug Abuse Task Force, warned that, "The effects of cocaine if used intensively--particularly if injected--are not well known...recent laboratory studies with primates, as well as reports of the effects of chronic cocaine injection during the early 1900's suggest that violent and erratic behavior may result. For this reason, the apparently low current social cost must be viewed with caution; the social cost could be considerably higher if chronic use began to develop."

The Introduction to Cocaine: 1977, a monograph produced by the National Institute on Drug Abuse (NIDA), expressed a similar view. It stated that "if cocaine becomes cheaper and more readily available, dosages will undoubtedly rise and the more unpleasant and dangerous aspects of the drug may become more apparent."

Such warnings have indeed proved prophetic. In the last 15 years cocaine abuse has grown from a relatively minor problem to a major public health threat. Our most recent surveys indicate that the number of new cocaine users has begun to level off, at least among those under 26, and young people are reporting increased awareness of the negative consequences associated with the drug. Nevertheless, we are definitely seeing the impact of the dramatic increases in cocaine use in the late 1970's and of heavier use among certain subgroups of cocaine users in greatly increased demand for treatment of dependence and numbers of medical emergencies associated with cocaine use.

The adverse consequences of cocaine abuse are now abundantly evident, as reflected in the popular media, our statistical data, and the medical literature. From each of these sources, we have dramatic evidence of the destructive powers of this drug.

Incidence and Prevalence

Our statistical data give us some idea of the overall dimensions of the cocaine problem. While the limitations of our data prevent us from making precise statements about the full extent of cocaine abuse and dependence in the United States, the dramatic increases in cocaine use since the early 1970's are well documented. For example, we know from the National Household Survey, which is conducted periodically by NIDA, that the number of people trying cocaine at least once (lifetime prevalence) increased from 5.4 million in 1974 to 21.6 million in 1982. The number of current users

(which we define as any use in the past 30 days) of cocaine increased from 1.6 million in 1977 to 4.3 million in 1979 and remained stable at about 4.2 million in 1982. I should note that the 1985 Household Survey, which includes additional questions on cocaine use, is now in the field. Data from that survey will be available shortly after the first of the year.

Further examination of data from the National Household Survey on Drug Abuse demonstrates that the young adult group (18-25) is clearly the predominant cocaine-using group. However, between 1979 and 1982, the trends for use in the past year (annual prevalence) among both youth (12-17) and young adults stabilized or decreased slightly while the trend among older adults (age 26 and older) increased (Figure 1). This suggests a cohort effect; that is, those who began to use cocaine when they were younger than 25 have continued to use the drug.

Today cocaine use is distributed throughout our population (Table 1). While cocaine use appears to be higher among those with at least a high school diploma or those who are employed, it should be noted that use is found in all income groups. Lifetime prevalence for adults reflects male predominance in illicit drug use that has been the pattern in our society. Among youth (ages 12 to 17), lifetime prevalence rates for males and females are almost equal. This may reflect a slowly narrowing gap in use of illicit drugs between younger males and females.

Data from the 1984 NIDA-Funded High School Senior Survey reflect trends similar to those seen in the National Survey (Table 2). Both annual and

lifetime prevalence of cocaine use have remained relatively stable over the past 3 years. However, this year there was a significant increase in "current" cocaine use; 5.8 percent of the senior class using cocaine at least once during the 30 days prior to the survey. This equals the previous peak of current cocaine use which occurred in 1981. Much of this increase was driven by the sharp rise in current use of cocaine in the Northeast (Figure 2).

As part of an experiment designed to ascertain the extent to which data from opinion polls can be used to supplement data from the major drug surveys, questions on the prevalence of alcohol, marijuana, and cocaine use have been added to recent Gallup Polls. Preliminary analysis of that data indicates that current use among males aged 18 to 34 is stabilizing (Table 3).

It seems that today some people view cocaine use as if it were a separate drug-using phenomenon. On the contrary, people who use cocaine have already experienced the use of other drugs, especially marijuana; 98 percent of people who have tried cocaine in their lifetime have also used marijuana and at least 93 percent of those used marijuana first. Furthermore, the probability of cocaine use increases with the frequency of marijuana use Table 4). Nearly three-fourths of those who have used marijuana 100 or more times have tried cocaine. A similar pattern was found in the High School Senior Survey, where 84 percent of the current cocaine users are also current marijuana users. In addition, 80 percent of the high school seniors who have used cocaine in the past month report having 5 or more drinks on at least one occasion in the 2 weeks prior to interview, and 50 percent smoke cigarettes daily.

Data from the Gallup Poll indicate that cocaine users not only use other drugs, but also that they often use these drugs in combination with cocaine (Table 5). The five most prevalent drugs used in combination with cocaine are alcohol, marijuana, tranquilizers, opiates, and amphetamines.

Health Consequences

Adverse health effects of cocaine use do not always occur with the first use of the drug. Consequently, it is necessary to contrast the trends in use of cocaine with the trends in medical emergencies and demand for treatment services related to cocaine use. It is not at all surprising that even though the most recent surveys of prevalence of use indicate that the number of new cocaine users has leveled off (at least among those under 26), the impact of the dramatic increases in cocaine use in the late 1970's is becoming more and more visible in terms of demand for treatment of dependence and medical crises associated with cocaine use.

We have a good deal of concrete data on the adverse health consequences of cocaine. As part of its national leadership role in the area of drug abuse, NIDA collects statistics on drug-related hospital emergency room visits and medical examiner cases through the Drug Abuse Warning Network (DAWN). Data on admissions to drug abuse treatment are collected on a voluntary basis, and currently there are approximately 15 States that report these data to NIDA.

(7)

Data from DAWN indicates that emergency room admissions associated with cocaine use increased approximately three and one-half times between 1976 and 1981. More recent data, based on a subset of emergency rooms that have consistently reported to DAWN since 1981, indicate that this upward trend continues unabated. There has been a particularly dramatic rise in cocaine mentions from emergency rooms since the first quarter of 1983 (Figure 3).

Recently, NIDA initiated a special study of cocaine trends using a 9-year panel of consistently reporting hospitals from DAWN. The data reflect almost an 8-fold increase in the rate of emergency room visits for cocaine related problems per thousand emergency visits (0.062 to 0.481). While the increase in rate has been greater for hospitals located in the central cities, parallel increases have also been seen in hospitals located in areas surrounding the center city (Figure 4). Recent top 10 city rankings are noted in Table 6.

There has been a slight increase in the percentage of females reporting to emergency rooms for cocaine problems--from 31 percent in 1975/76 to 34 percent in 1983/84. An aging of the population of cocaine users has also been noted. In 1975/76, 25 percent of the individuals involved in cocaine episodes were 30 years or older, while in 1983/84, 41 percent were 30 years or older. Generally, females using cocaine tend to be younger than males. Forty-five percent of males involved in cocaine abuse episodes were over the age of 30 versus approximately one-third of the females.

53-440 O - 86 - 5

As has been mentioned previously, cocaine users often use other drugs. In more than two-thirds of the cocaine-related emergency room episodes there has been an implication of other drugs used in combination with cocaine. Table 7 lists the top 10 combinations of drugs reported in DAWN emergency rooms from January to November 1984. Cocaine is mentioned in 3 of the top 10. The combination of heroin and cocaine, known as "speedball," was the second most frequently mentioned combination in DAWN.

Table 8 displays some demographic characteristics for selected combinations. For example, only 7 percent of all cocaine mentions involve people under 20, whereas 18 percent of the mentions of cocaine and marijuana in combination involve this age group.

Increases have also been noted for admissions to publicly-funded drug treatment programs. Our data indicate that in 1983, primary cocaine problems accounted for 7.3 percent of all admissions and secondary cocaine problems for 10.5 percent. For the first 6 months of 1984, however, primary cocaine problems represented 13.9 percent of all admissions, and secondary cocaine problems represented an additional 14.8 percent of admissions. Thus, more than one-fourth (28.7%) of the treatment clients now reported to NIDA have a problem with cocaine use.

While snorting or inhalation continues to be the predominant mode of administration, representing 57 percent of recent treatment admissions, freebasing or smoking of cocaine increased substantially from less than 1 percent in 1977 to 4.7 percent in 1981 and is now reported as the mode of

administration by 16 percent of primary cocaine clients. Injection as a route of administration was involved in almost 25 percent of the cocaine related admissions. It is important to note that injection related cases represent admissions for primary cocaine problems and, thus, they are not reflective of the speedballing population, who generally report cocaine as their secondary problem. Consistent with both survey and DAWN data, cocaine treatment clients often use other drugs. Eighty-one percent of primary cocaine admissions in 1984 also reported problems with other drugs.

In summary, epidemic increases in the incidence of cocaine use occurred in the country in the mid to late 1970's. Although 1982 survey data provide some evidence of new use among the population aged 26 and older, there is no evidence of significantly increased levels of <u>new use</u> of cocaine in the general population.

At the same time, we are continuing to see large increases in the number of persons seeking treatment for the problems associated with their use of cocaine. One reason for this is that there is generally a time lag of several years between the onset of cocaine use and entry to drug abuse treatment. This increase may also reflect a pattern of more frequent use by a subset of the cocaine-using population. Data on treatment admissions and from emergency rooms suggest a trend toward more dangerous routes of administration, such as injection and freebasing, although, at least for treatment admissions, snorting is still the predominant mode of administration.

Effects of Cocaine Use

Despite the fact that increasing numbers of individuals are entering treatment for problems associated with cocaine use, there still appears to be a pervasive belief in our society that cocaine is not an addictive drug. This belief may have arisen because of the tendency to equate a drug's addictive potential with the occurrence of dramatic physical and physiological withdrawal symptoms when its use is discontinued. The evidence as to whether or not discontinuing cocaine use precipitates physical or physiological withdrawal symptoms in all individuals appears to be inconclusive. Further, the manifestations of withdrawal from cocaine are more like signs and symptoms of depression than the more obvious distress seen after withdrawal of opioids or sedatives.

However, let me emphasize that there is absolutely no question that cocaine is one of the most powerfully addictive drugs known, exerting its effect by acting directly on the reward or pleasure centers of the brain. This action produces an intense desire to experience the effects of cocaine again and accounts for the development of compulsive use beyond the control of the user. In fact, the strength of the reinforcing properties of cocaine are greater than those of heroin, and, in that sense, it is "more addictive."

Cocaine's positive reinforcing properties have been demonstrated in every species of animal tested. In addition, if access to the drug is not limited, there is evidence that animals will self-administer cocaine to the point of toxicity and death, selecting cocaine in preference to food and

water. By contrast, animals will not self-administer opiates, even heroin, to the point of such toxicity.

It is clear that the amounts of cocaine used and frequency of use vary widely across individuals, and categorizations of users by amount and frequency of use are necessarily somewhat arbitrary. A substantial number of users (nearly 20 percent in one study) become compulsive users, so preoccupied with obtaining and using cocaine that all their other activities, including eating and sleeping, become severely limited.

The immediate, or acute, effects of cocaine are perceived by users to have both positive and negative components. Most individuals report that their first use of cocaine produced an almost immediate pleasurable effect, whether they administered the drug orally, intranasally, or intravenously. Some of the perceived positive effects include euphoria, a sense of power, reduced fatigue, diminished appetite, sexual stimulation, increased sociability, and improved ability to function mentally. Users also commonly report that many of these initial sensations are difficult or impossible to recapture with repeated use of the drug.

At the same time, the drug produces a number of markedly negative effects. The reported negative health consequences or symptoms of cocaine use include weight loss, increased heart rate and blood pressure, depression, irritability, anxiety, paranoia, and hallucinations. Not surprisingly, negative effects appear to be more common among compulsive users. One study found that compulsive users reported negative effects in 82 percent of the

intoxications and the absence of positive effects in 15 percent. Both depression and psychosis are more likely to occur with chronic heavy use.

Increased doses of cocaine also place the user at high risk for acute toxic reactions, including cocaine-induced seizure and convulsions, respiratory function disturbances, cardiac arrhythmia, and myocardial infarction. Cocaine overdose can result in seizures, coma, and death from respiratory or cardiac arrest. The data from NIDA's Drug Abuse Warning Network, cited earlier in my testimony, certainly bear out the fact that cocaine can have extremely toxic effects on its users.

NIDA's Role in Cocaine Research

It should be clear that the Department regards cocaine as a significant public health problem, both in terms of the number of users and the serious adverse consequences for which these users are at risk. In addition to our continuing efforts to track trends in cocaine use and to refine our data sources to get an even more accurate picture of the dimensions of the problem, the National Institute on Drug Abuse is devoting an increasing proportion of its resources to research aimed at understanding exactly how cocaine works, what its effects are, and what treatment and prevention approaches are most efficacious in dealing with this particular drug. In 1984, for example, the Institute funded approximately 23 grants related to cocaine and other stimulants.

To encourage additional research, in 1984, NIDA distributed a new research announcement to the field inviting applications for studies to broaden

understanding of cocaine use and help identify effective strategies for treatment and prevention. This research is to focus on a number of areas, including etiology, biomedical aspects, neuroscience, behavioral pharmacology, treatment, and prevention. This represents a significant expansion in our research portfolio on cocaine.

Last year, NIDA published Cocaine: Pharmacology, Effects, and Treatment of Abuse. The monograph discusses the scientific evidence that cocaine is powerfully addictive and describes how it activates reward circuits in the brain. It also discusses current and experimental treatment for cocaine abuse. In July of 1984, NIDA held a national symposium on cocaine for the purpose of developing a comprehensive description of patterns and consequences of cocaine use in this country. Prominent clinicians, researchers, and epidemiologists presented papers now being prepared for publication in another monograph entitled Cocaine Use in America: Epidemiologic and Clinical Perspectives, which is expected to be released in early Fall, 1985.

NIDA has also been working in close collaboration with the World Health Organization in order to develop a global strategy to combat cocaine abuse.

Treatment Research

Research into the treatment of cocaine abuse has become an important priority area for this Department. Before I briefly review what we have learned from this research, it is important to remember that all our data

tell us that the cocaine-using population is a multi-drug-using population. In addition, the apparent heterogeneity of cocaine users, in terms of demographic, socioeconomic, cultural, and environmental characteristics, combined with differing drug use patterns and combinations, suggests that a number of different treatment settings and approaches may be required to deal with the cocaine problem. There is not--and will not be--a magic bullet for curing cocaine dependence, and clinicians will continue to need to match the therapy to the individual client. Nevertheless, we have learned a good deal about several approaches which seem to work for many individuals. These include psychotherapy, behavior modification, self-help strategies, and various pharmacotherapies.

Clinicians and scientists at the Johns Hopkins School of Medicine, the University of California at San Francisco, the University of Pennsylavania, McLean Hospital in Boston, NIDA's own Addiction Research Center, and other institutions have been examining the specific behavioral and environmental factors contributing to the development, maintenance, and elimination of drug taking behavior. In the meantime, by working with cocaine addicts, clinicians--several of whom are funded by NIDA--have developed treatment principles based on experiences with the real and everyday interactions that the former drug user must confront.

For example, Dr. Tom Crowley at the University of Colorado has applied knowledge in this area to devise a unique but controversial treatment for cocaine abusing medical professionals. Dr. Crowley devised techniques which not only precluded hospitalization, but took advantage of his patients' need

to learn to work without abusing drugs while being exposed daily to their availability. He used the intervention techniques of behavior modification therapy to assure compliance with a nondrug-using lifestyle. Specifically, by using the technique of contingency contracting, Dr. Crowley achieved dramatic and abrupt reductions in drug use. The patients remained in their usual environment and continued to work at their professions, while unlearning previous compulsive drug using behaviors and learning new ways to interact with their colleagues, friends, and families. Dr. Crowley took advantage of all of the normal activities available in the environment to enhance the likelihood of success.

Other treatments for cocaine abuse take advantage of the more traditional psychotherapeutic strategies. As is often the case with chronic high-frequency abusers of psychoactive drugs, many cocaine abusers demonstrate marked psychopathologies. Whether these pathologies caused or contributed to, or were caused or exacerbated by, the substance abuse, they must be a focus of treatment. It is a rare chronic abuser who does not demonstrate social or psychological areas of impaired functioning, even after the substance abuse behaviors have been discontinued. A diagnosis of the individual's particular pathology must be accomplished and a treatment plan developed accordingly. For a few, usually more moderate abusers, shorter term, more directive systems and/or cognitively-oriented psychotherapeutic strategies may be sufficient interventions. For the large majority of abusers, specific attention must be given to confronting and overcoming the drug use behaviors themselves. This may be accomplished through the behavior modification techniques already mentioned or, in many

cases, through the types of psychotherapeutic strategies proven effective with alcoholics and other substance abusers.

The application of self-help strategies is another promising area of research for the treatment of cocaine abusers. These strategies might be used with clients after they complete traditional inpatient or outpatient programs. Cocaine Anonymous, modeled closely after Alcoholics Anonymous, is one such aftercare group. Some leading investigators are also actively researching the use of professionally guided self-help groups as a primary intervention for cocaine abusing individuals.

In addition to behavior modification therapy, psychotherapy, and self-help groups, some patients may require treatment with psychotherapeutic drugs. Some investigators, including Drs. Kleber and Gawin at Yale, have suggested that chronic cocaine abuse may lead to neurophysiological adaptations which require more than psychological intervention. They are evaluating various drugs with some similarities in physiological effect to cocaine as possible replacements from which the cocaine abuser could be weaned. These investigators have pursued the study of drugs explicitly known to be effective in the treatment of depression. The results of such studies suggest that the tricyclic antidepressants might be particularly effective in attentuating cocaine-induced psychological changes. In addition, these drugs may help in the treatment of those individuals whose depressive disorders have predisposed them to chronic cocaine use. Other drugs, including methylphenidate and lithium, are being investigated and may be of special value for treating specific subpopulations of cocaine users.

In addition to the aforementioned agents with which we are already familiar, there are, of course, numerous new drugs under development. These drugs may not only assist in the treatment of cocaine use, but may also help us better understand the mechanisms by which cocaine controls behavior.

As important as we consider our research on cocaine treatment, it is equally important that we disseminate the results of that research to the practitioners who can make use of them. In addition to the monographs mentioned above and other publications produced by the Institute, NIDA has developed a number of other mechanisms for disseminating knowledge to the field. During the past year, there have been a series of symposia--in Portland, Boston, Atlanta, Los Angeles, New York, Dallas, and Chicago--designed to disseminate research-based treatment knowledge to practioners. Each symposium had three workshops: Treatment of Cocaine Dependence; Treatment of Adolescent Substance Abusers; and How to Provide Aftercare/Self-Help Services. In April of this year, in Milwaukee, the Wisconsin Institute on Drug Abuse and the Tellurian Society, with NIDA as co-sponsor, held a national symposium on cocaine. Surgeon General Dr. C. Everett Koop gave the keynote address on "Cocaine and Health," and former NIDA Director Dr. William Pollin spoke on the topic of "Cocaine--A Powerfully Addictive Drug." Other NIDA staff and a number of NIDA-supported researchers presented information on current activities and findings in cocaine research, prevention, and treatment. More than 400 health professionals, law enforcement personnel, alcohol and drug abuse professionals, researchers, and industrial representatives attended this meeting.

Prevention

Finally, I would like to summarize our current activities in another area which I believe holds promise for solving our cocaine problem—prevention. Since our data very clearly indicate that cocaine use is not a phenomenon separate from other drug use, all of our activities in the area of primary drug abuse prevention--whether they are focused on cigarettes, alcohol, or marijuana--can be expected to have an effect upon cocaine use as well.

At the same time, we are developing other activities specifically aimed at the prevention of cocaine use. Last November, NIDA convened a Cocaine Prevention Discussion Group made up of experts in the field. At that first meeting, the group worked on defining the problems in cocaine prevention and developing a broad range of prevention recommendations. They felt that there was a pressing need for the dissemination of new research and epidemiological information, in understandable language, to all segments of the general public. This March the group met again, reviewed the progress that has been made in materials development, and identified a number of new or revised resource materials, including books, pamphlets, films, and videotapes. The group is also developing a network for disseminating this knowledge through a wide range of public and private-sector agencies. NIDA itself is developing a resource package to provide to individuals and groups interested in becoming involved in cocaine prevention activities.

Another activity in the area of cocaine prevention is a nationwide media campaign, planned to begin in January, 1986. Early last month, NIDA signed

a contract with the Advertising Council for this campaign, which is designed to increase and maintain the public's attention to the health and psychological consequences of cocaine use. The campaign's primary audience will be young adults, 18 to 35 years old, including those working and in college. We want to encourage and support the ability of young people and other potential users to resist the pressure to use cocaine. Families, friends, employers, and coworkers will be secondary target audiences.

We have learned that young people respond best to serious, authoritative information, and we intend to use messages that deal directly and specifically with the known health consequences of cocaine. Needham, Harper Worldwide, the volunteer ad agency that designed NIDA's recent "Just Say No" prevention campaign, will also work with the Ad Council on this project. In addition to television and radio spots, the campaign will include print ads and articles in newspapers and magazines, transit ads, information bulletins and fact sheets, posters and other collateral materials, and exhibits at meetings and conferences. We believe that the campaign will be successful in increasing awareness of cocaine as a dangerous dependence-producing drug and in changing societal attitudes toward it. It is our hope that these changes in turn will affect a downturn in cocaine use.

In summary, we at the Department of Health and Human Services are extremely concerned about the threat cocaine use represents to our citizens. In order to deal with the greatly increased numbers of negative health consequences and the special treatment needs manifested by cocaine users, we are devoting--and will continue to devote--considerable resources to research,

including treatment research, and prevention activities focusing on cocaine use.

This hearing itself will focus a great deal of national attention on the dangers of cocaine use. I am grateful for the opportunity to testify today and will be happy to answer any questions you may have.

(21)

Table 1

Cocaine Use, 1982 Household Survey

Subgroup	% Ever Used		% Used in Past Month	
	Youth 12-17	Adults 18-44	Youth 12-17*	Adults 18-44
Total	6.5	22.0	* N is too small to report	4.3
Sex				
Male	6.5	28.0		6.0
Female	6.4	16.3		2.7
Race				
White	6.8	23.7		4.7
Other	5.3	15.3		2.4
Region				
Northeast	8.3	25.4		6.9
North Central	3.4	17.3		3.4
South	5.7	15.8		2.2
West	10.0	34.1		5.8
Population Density				
Large Metro	9.0	25.9		5.0
Other Metro	5.4	22.5		4.5
Non-Metro	4.2	14.7		2.7
Education				
High School Graduate	N/A	23.3		4.5
Not H.S. Graduate		14.6		2.7
Employment				
Employed	N/A	24.3		5.0
Not Employed		15.3		2.2
Occupation				
Not Asked	N/A	15.2		2.2
Professionals/Managers		28.4		5.9
Skilled/Retail		19.9		4.2
Other		23.8		4.7
Family Income				
Under $10,000	Unavailable	26.1		3.9
$10-19,999		24.3		5.6
$20-29,999		20.0		2.7
Over $30,000		20.6		4.6
Unknown		13.4		3.0

Table 2

Trends in Current, Annual and Lifetime Prevalence
of Cocaine Use Among High School Seniors
(Percent of Seniors in Class)
1975 - 1984

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
Current	1.9	2.0	2.9	3.9	5.7	5.2	5.8	5.0	4.9	5.8
Annual	5.6	6.0	7.2	9.0	12.0	12.3	12.4	11.5	11.4	11.6
Lifetime	9.0	9.7	10.8	12.9	15.4	15.7	16.5	16.0	16.2	16.1

(23)

Table 3

Current Prevalence
of Cocaine Use by U.S. Males

H = Household Survey
G = Gallup Poll

	1979(H)	1982(H)	1984(G)
Ages 18-25	11%	9%	10%
Ages 26+	1%	2%	2%

Table 4

Cocaine Use Among Adults 18 Years and Older
According to Recency and Frequency of Marijuana Use

Recency of Marijuana Use	% Ever Used Cocaine	% Never Used Cocaine
Never used marijuana	0.3	99.7
Used marijuana, but 10 times and not past month	11.2	88.8
Used marijuana 10 times, but not past month	44.2	55.8
Used marijuana in past month	68.4	31.6
Frequency of Marijuana Use in Lifetime		
Never	0.3	99.7
1-2	1.8	98.2
3-10	21.8	78.2
11-99	40.8	59.2
100+	74.0	26.0

Recency of Marijuana Use	% Used Cocaine in Past Month	% Not Used Cocaine in Past Month
Never used marijuana	0.0	100.0
Used marijuana, but 10 times and not past month	1.0	99.0
Used marijuana 10 times, but not past month	7.5	92.5
Used marijuana in past month	15.0	85.0
Frequency of Marijuana Use in Lifetime		
Never	0.0	100.0
1-2	0.4	99.6
3-10	2.4	97.6
11-99	9.4	90.6
100+	14.1	85.9

Source: NIDA, 1982 National Survey on Drug Abuse

(25)

Table 5

Percent of Last Year Cocaine Users Combining
Other Drugs With Cocaine
By Age Group and Drug Combinations
U.S. Males, 1984

	Total	18-25 yrs.	25-34 yrs.
Cocaine + Alcohol	49%	34%	60%
Cocaine + Marijuana	35%	27%	50%
Cocaine + Tranquilizers	5%	9%	3%
Cocaine + Opiates	4%	4%	4%
Cocaine + Amphetamines	1%	10%	9%

Table 6

Rate of Cocaine Emergency Room Episodes
Per 1000 Emergency Room Visits For All Causes
(Selected Cities, Jul 83-Jun 84)

Rank	City	Rate
1	Miami	3.062
2	San Francisco	2.50
3	New Orleans	1.848
4	New York	1.441
5	Los Angeles	1.197
6	Detroit	1.195
7	Seattle	0.712
8	Chicago	0.509
9	Denver	0.506
10	Washington, D.C.	0.466

(27)

Table 7

Top 10 Drug Combinations:

DAWN Emergency Room Mentions

Jan-Nov 1984

OBS	Full Name	Frequency
1	Alcohol-in-Combination X Diazepam	2472
2	Cocaine X Heroin/Morphine	2250
3	Alcohol-in-Combination X Heroin/Morphine	2042
4	Alcohol-in-Combination X Cocaine	2041
5	Alcohol-in-Combination X Marijuana	1688
6	Alcohol-in-Combination X PCP/PCP Combinations	1123
7	Cocaine X Marijuana	922
8	Alcohol-in-Combination X Aspirin	703
9	Acetaminophen X Alcohol-in-Combination	650
10	Alcohol-in-Combination X Diphenylhydantoin Sodium	644

Source: NIDA, Drug Abuse Warning Network (DAWN)
November 1984 Total Data File

Table 8

Sex, Race, and Age Distributions for Cocaine Mentions and for Leading Combination in DAWN Emergency Rooms Jan-Aug 1984

	Cocaine	Cocaine and Heroin	Alcohol and Cocaine	Cocaine and Marijuana
Sex				
Percent Male	66	70	65	71
Race				
Percent White	39	27	48	49
Black	42	55	35	34
Hispanic	12	13	12	13
Age				
Percent 20	7	2	9	18
20-29	52	43	53	56
30	41	55	37	26
Total Number	6,117	1,442	1,320	922

Source: NIDA, Drug Abuse Warning Network (DAWN) August 1984 Total Data File

Figure 1

Past Year Cocaine Use by Age Group

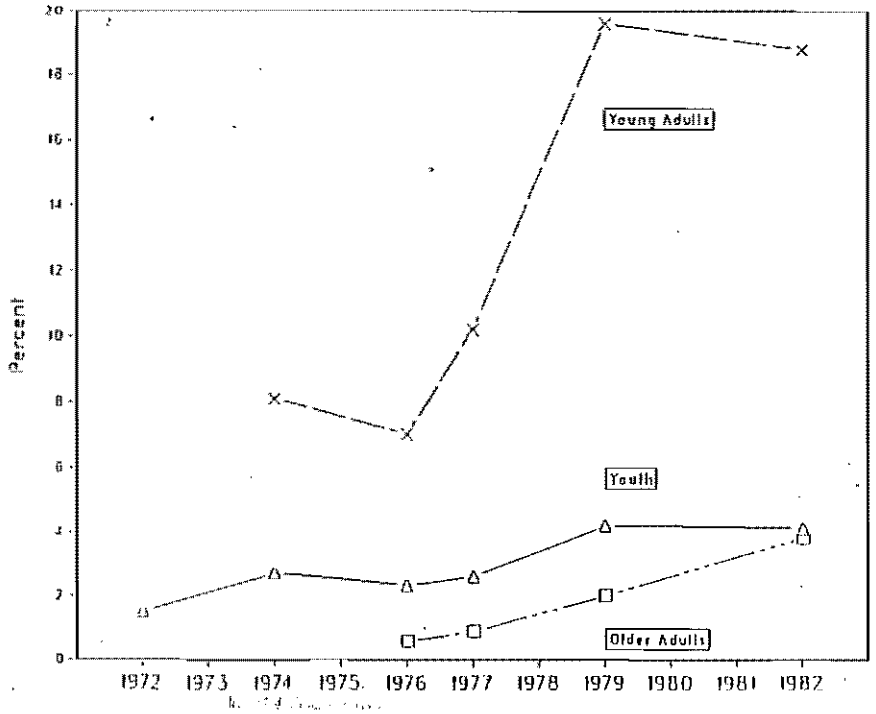
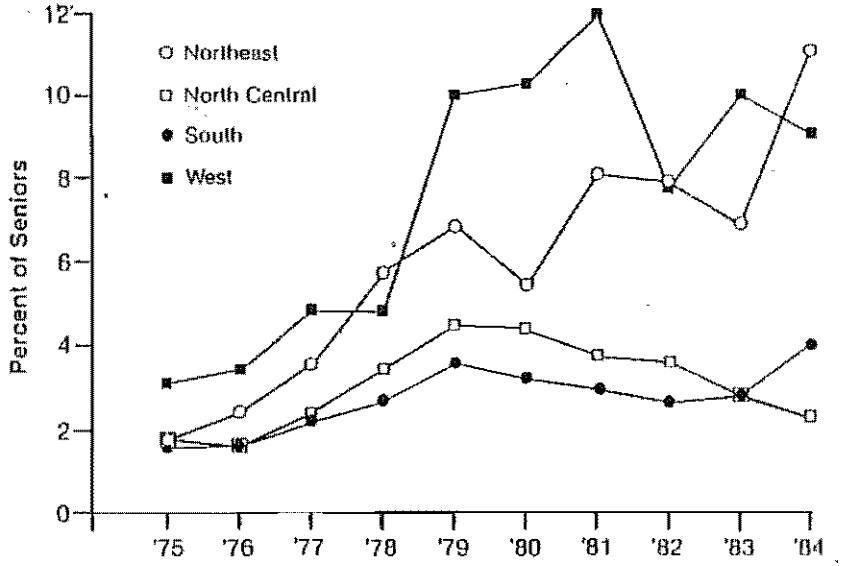


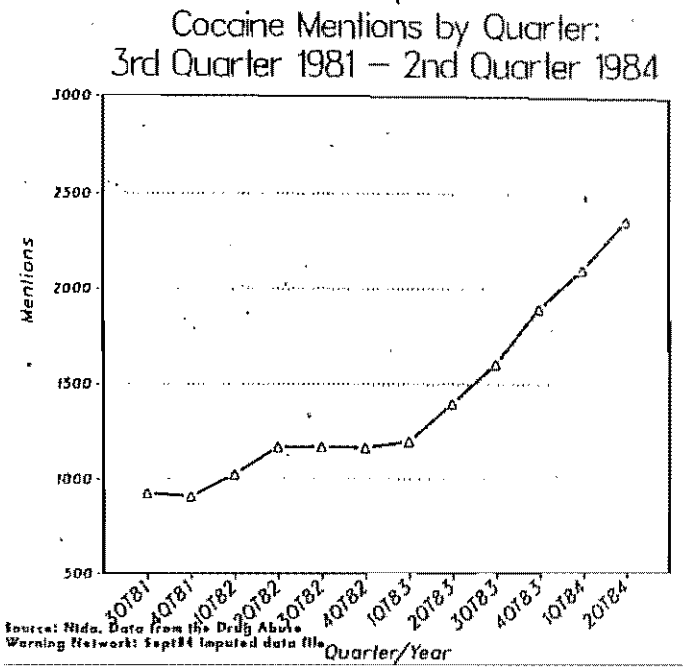
Figure 2

Current Use: Cocaine
Among High School Seniors According to Region



Note: Current use is defined as use at least once in past 30 days.
Source: NIDA, Monitoring the Future Study.

Figure 3



Source: Nida. Data from the Drug Abuse Warning Network: Sept84 imputed data file

Figure 4

EMERGENCY ROOM DATA
Rates Analysis based on Center City versus Outside Center City
Number of Cocaine Mentions per 1,000 ER Visits
0.75
0.50
0.25
0
75-76
76-77
77-78
78-79
79-80
80-81
81-82
82-83
83-84
Year
Legend
Both
Center City
Outside Center City

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Alcohol, Drug Abuse and
Mental Health Administration
Rockville MD 20857

Dear Colleague:

This prevention resource package contains some of the most recent information available on cocaine.

Its purpose is to describe briefly aspects of the drug from its early history, to its current reemergence as a popular illicit drug. Much of our knowledge and understanding of cocaine has been developed within the past five years — a relatively short time in the known history of the drug and its use.

Our hope is to make the recent research findings accessible to the general public, in order to permit an understanding of the complex nature of the drug, dispel the many myths about the effects of cocaine, and to bring attention to the serious risks to the health and well-being of those who come in contact with this powerfully addictive drug.

The enclosed summary provides a historical context for cocaine, describes use patterns for the drug, reviews current scientific research issues, having implications for the prevention and treatment of cocaine use, and presents a resource list of books, monographs, magazine and newspaper articles, films and videotapes, and State and local contacts for additional information resources.

Those fortunate enough to live near a university or college library may also be able to obtain bibliographic searches on cocaine as well as other drug topics. Libraries, in most States, can arrange for interlibrary loans of materials not available from their stacks. Many magazines and newspapers have a reprint service for a nominal charge. You should contact the publishers directly or a reference librarian for information about this service. Addresses of publishers are available in Books In Print; this reference lists hardback and paperback editions by title and by author.

As you read the accompanying resources it is important to consider how they may be used in your own drug abuse prevention activities. Information-sharing is only one aspect of substance abuse prevention programming.

To aid you in planning your local prevention activities, you will find in this package information resources for community-based prevention planning. These are described in the following paragraphs.

Basic prevention planning from the initial and vital needs assessment through the steps of program implementation is covered in the Prevention Planning Workbook. This is an excellent resource for the process of developing a prevention effort tailored to a community's unique needs.

The Community Development Approach: A New Model for Drug and Alcohol Abuse Prevention provides a demonstrated philosophy and methodology for a comprehensive approach to community prevention planning. It was developed through the efforts of the Eagleville Hospital and the Pennsylvania Department of Health, Office of Drug and Alcohol Programs. It is a rich source for guidance to a community-wide prevention effort.

Information on cocaine as well as other drugs is available from the National Clearinghouse for Drug Abuse Information. Ordering information is included in the enclosed list of publications.

For information about prevention planning and programs in your locality you can contact your Single State Authority (SSA) at the address on the list of additional resources. If you have additional questions about prevention programming or the enclosed materials, please write to the Prevention Branch at Room 10A-54, 5600 Fishers Lane, Rockville, Maryland 20857.

The content of this cocaine information packet cannot provide the total picture. It can provide information useful to your community's needs.

Sincerely yours,

Bernard R. McColgan
Chief, Prevention Branch
National Institute on Drug Abuse

Enclosure

PREVENTION BRANCH

DIVISION OF PREVENTION
AND
COMMUNICATIONS

NIDA

COCAINE

A Capsule Overview

- History
- Defining the Problem
- Research and Scientific Issues
- Treatment of Cocaine Abuse
- Prevention Issues
- Cocaine: Selected Annotations
- Additional Reading

JUNE 1985

HISTORY OF COCAINE USE

For a period of more than 4,700 years, cocaine has been used in religious, magical, medical, and recreational contexts by the indigenous populations of South America. In 1580, following the Spanish invasion of this area, cocaine was introduced into Europe. Preparations of coca leaves and its extracts were incorporated into wines, liquors, cordials, lozenges, tobacco products, and chewing gum. Cocaine's efficacy as a topical anesthetic was discovered in the mid-nineteenth century.

General observations on the patterns of cocaine consumption began to appear in both the medical and lay press in the early twentieth century. Some articles suggested that cocaine use was associated with uncontrollable addiction, physical and psychological deterioration, demoralization, and criminal violence.

Legal control of cocaine in the United States began with the Pure Food and Drug Act of 1906. The passage of the Harrison Narcotic Act in 1914 launched a period of effective cocaine prohibition by restricting and controlling all aspects of its manufacture, possession, sale, distribution, and use. Both the medical and nonmedical use of cocaine gradually declined, and general interest in the drug slackened considerably between the 1930s and the late 1960's.

Before the Federal legislation was passed, cocaine extracts were widely available in elixirs, lozenges, and other patent medicines throughout the United States and were an integral ingredient in the syrup used to make Coca Cola. The Coca Cola Company ceased using the coca extract in 1903, before the laws restricting its use were proposed.

A resurgence of cocaine use began in the early 1970s and has continued on into the 1980s. "Cocaine is for the 1980s what marijuana was for the 1970s: a mass appeal chic drug with an undeserved reputation as safe, or almost safe ..... Cocaine shares with alcohol, especially with champagne, the image as the party drug of the rich, a way to reward yourself extravagantly." (DuPont 1984).

The myths surrounding cocaine enhance this appeal. Among these are:

- cocaine is an aphrodisiac
- cocaine increases creative and physical performance
- there are no bad effects from cocaine use
- a cold shower is an antidote for cocaine intoxication

Current research establishes that cocaine may well be the most powerfully addicting of known substances. That this statement involves a redefinition of addiction will be described in the section reviewing current research.

DEFINING THE PROBLEM

Public concern about cocaine has grown with increased public awareness of cocaine's popularity and dangers. As the accompanying data indicate, that concern is well justified. As of 1982, more than 21 million persons were reported as having used cocaine at least one time in their lives, making it the second most frequently used illicit drug. Moreover, in a survey of high school seniors, cocaine was found to be the only drug, other than inhalants, for which recent use was increasing.

The statistical presentation below is taken from published summaries of the National Household Survey and the High School Seniors Survey, the two primary survey data bases available to the National Institute on Drug Abuse. The National Household Survey, conducted every two to three years, provides reliable information regarding national drug use patterns. The High School Seniors Survey is conducted annually and is held in similar high regard in the research community.

Cocaine is now seen by many health care experts as the single most rapidly growing drug problem (excluding alcohol) for this nation. As one expression of the problem, cocaine presently demonstrates the most rapidly accelerating rate of emergency room mentions reported through The Drug Abuse Warning Network (DAWN). The following data provide a statistical description of the cocaine problem.

TRENDS IN PAST YEAR AND PAST MONTH USE OF COCAINE BY AGE CATEGORY
1972-1982

	Estimated Percent of the Household Population					
	1972	1974	1976	1977	1979	1982
Age 12-17						
Used in Past Year	1.5%	2.7%	2.3%	2.6%	4.2%	4.1%
Used in Past Month	.6	1.0	1.0	.8	1.4	1.6
Age 18-25						
Used in Past Year	N/A	8.1	7.0	10.2	19.6	18.8
Used in Past Month	N/A	3.1	2.0	3.7	9.3	6.8
Age 26 and Above						
Used in Past Year	N/A	*	.6	.9	2.0	3.8
Used in Past Month	N/A	*	*	*	.9	1.2

N/A = Not available
* = Less than 0.5%

Estimated Projections of the Household Population--1982

	Age 12-17	Age 18-25	Age 26 & Older	Total
Ever Used Cocaine	1,490,000	9,260,000	10,820,000	21,570,000
Current Use of Cocaine	380,000	2,230,000	1,550,000	4,170,000

Note: Current use is defined as use one or more times in the month prior to survey.
Source: National Institute on Drug Abuse, National Survey on Drug Abuse 1982.

TRENDS IN PAST YEAR AND PAST MONTH
USE OF COCAINE BY HIGH SCHOOL SENIORS
1976 - 1984

Percent of High School Seniors

	1976	1977	1978	1979	1980	1981	1982	1983	1984
N*=	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)
Used Past Year	6.0%	7.2%	9.0%	12.0%	12.3%	12.4%	11.5%	11.4%	11.6%
Used Past Month	2.0%	2.9%	3.9%	5.7%	5.2%	5.8%	5.0%	4.9%	5.8%

*Approximate sample sizes by year.

Source: National Institute on Drug Abuse, High School Seniors Survey, 1976-1984.

CONSEQUENCES OF COCAINE USE

TRENDS IN HOSPITAL EMERGENCY ROOM MENTIONS OF COCAINE

1981 - 1983

	1981	1982	1983	1984
Total Mentions	3,443	4,731	5,394	8,717
New York	1,536	2,212	2,141	2,354
Miami	305	361	450	931
Detroit	152	180	423	558
Los Angeles	130	223	339	564
Chicago	154	172	235	494

Data for the first quarter of 1985 indicate that cocaine mentions in emergency rooms are continuing to increase.

Note: Data are derived from a panel of consistently reporting hospital emergency rooms located in 26 major U.S. metropolitan areas.

Source: NIDA, Drug Abuse Warning Network (March 1985 data file)

TRENDS IN MEDICAL EXAMINER MENTIONS OF COCAINE

1979 - 1983

	1981	1982	1983	1984
Total Mentions	195	217	323	578
Los Angeles	33	46	79	176
Miami	48	27	66	90
San Francisco	28	46	35	67
Washington, D.C.	5	8	30	57
Chicago	11	25	22	32

Note: Excludes data for the New York area because of incomplete reporting. Data are based on reports from Medical Examiners in 26 major U.S. metropolitan areas.

Source: NIDA, Drug Abuse Warning Network (March 1985 data file)

Recent statistical information further supports a concern about cocaine. Edgar Adams, Acting Director of NIDA's Division of Epidemiology and Statistical Analysis, notes the following:

> Epidemic increases in the incidence of cocaine use occurred in the country in the mid to late 1970s. Although 1982 survey data provide some evidence of new use among the population aged 26 and older, there is no evidence of epidemic levels of new use of cocaine in the general population. Preliminary analysis of data from the 1984 Gallup Poll suggests that both annual and lifetime prevalence of cocaine use in the population 18 to 34 may be stable, although there does appear to be an increase in current use of the drug. This increase may reflect a pattern of more frequent use by a subset of the cocaine-using population. Data on treatment admissions and from emergency rooms suggest a trend toward more dangerous routes of administration such as injection and freebasing, although, at least for treatment admissions, snorting is still the predominant mode of administration. The findings that the cocaine-using population, whether reflected in survey data, DAWN data, or treatment data is a multi-drug-using population, suggest that cocaine abuse may not be a singular syndrome. The apparent heterogeneity of cocaine users, in terms of demographic and socioeconomic characteristics, suggests that a number of different treatment settings and approaches may be required to deal with the cocaine problem.

RESEARCH AND SCIENTIFIC ISSUES

Highlights of new and emerging research findings are presented below in an outline or bulletin format to focus on key issues related to cocaine use. This information is available in detail in NIDA's Research Monograph 50 on cocaine (1985). This publication may be ordered from the National Clearinghouse for Drug Abuse Information at the address on the publication list attached.

Current research is discussed in some of the other references as well. One particularly clear resource is Getting Tough on Gateway Drugs: A Guide for the Family, by Dr. Robert L. DuPont (1984).

Although this is a complex scientific area, many of the articles in newspapers and popular, non-scientific magazines also review current research on cocaine and are in a style which is easy to understand.

RESEARCH ISSUES

- Cocaine appears to obtain its ability to stimulate euphoria and feelings of enhanced mental and physical capabilities through stimulation of brain reward centers. This reward is also the basis for cocaine's powerful reinforcing nature.

- Current research on reinforcing properties of various drugs indicates that it is the positive aspects (the euphoria, and feelings of omnipotence and enhanced creativity) which are most powerful in maintaining drug taking behavior. This is believed to be the case even for those drugs which lead to physical dependence and dose tolerance (e.g., heroin).

These new research findings have compelling implications not only for drug abuse treatment and prevention programming but for policymakers and other citizens who share concerns about the human experience. Roy Wise put it succinctly when he stated:

> The refinement of substances such as cocaine and methods such as rewarding brain stimulation which can activate central reward circuiting directly, are unlikely to serve the further evolution of man so long as they provide shortcuts to the pleasures of reward and bypass the adaptive activities that have led to these pleasures over most of our evolutionary history. (Wise, 1984, Research Mono 50)

PHARMACOLOGY

- Cocaine is readily absorbed by the mucosal linings of the mouth, nasal passages, lungs, etc.
- Acute cocaine poisoning may involve symptoms including extreme nervousness and agitation, convulsions, and heart and respiratory failure.
- Prolonged high dose use of cocaine in humans can be seen to lead to psychosis similar to that in high sustained amphetamine use. (Post et al., 1976, Research Mono 50).
- Research has shown that persistent and excessive efforts to obtain a drug are determined by the relationships of the drug's availability and its specific pharmacological properties.
- It has not been shown that cocaine enhances human performance in any activity.

TREATMENT OF COCAINE ABUSE

John Grabowski of NIDA's Division of Clinical Research talking about cocaine treatment states:

> As with many biobehavioral problems, of which drug abuse is one, the population seeking treatment is heterogeneous. The individuals vary along all dimensions that we usually think of, social class, age, employment, other drug experience and so on. Thus, as is often the case, there is a need to match the therapy with the needs of the patient.

There are some common elements to most treatment strategies for cocaine use. They are: abstinence (total) from cocaine, abstinence from all other psychoactive drugs (this may even include caffeine and nicotine), withdrawal and detoxification, integrated treatment involving significant others, and aftercare (Cohen, 1983; Miller, 1985, Research Mono 50).

Maintaining the abstinence condition in the cocaine abuser is one of the most challenging aspects of initial treatment. Kleber and Gawin in NIDA's Research Monograph No. 50 note that, "Cocaine users ultimately have to maintain abstinence within the general setting where abuse developed, and our impression is that a period of abstinence within the context of everyday stimuli and stressors, akin to a period of 'extinction', is a necessary prerequisite to consistent long-term reductions in craving. Like the former cigarette smoker or alcoholic, the person attempting to give up cocaine must make the drug psychologically unavailable since it is so hard to make it physically unavailable".

Grabowski further notes that:

> Clinicians and scientists have been examining in drug-abusing populations the specific behavioral and environmental factors contributing to the development, maintenance, and elimination of drug taking. This has led to innovative strategies for treatment of drug abuse using behavioral techniques.

BEHAVIORAL INTERVENTION TECHNIQUES

Thomas Crowley at the University of Colorado put behavioral intervention techniques to unique use in the treatment of the cocaine abusing professional. Knowing that the clients and patients of such professionals can ill afford to lose their services (for example the loss of a physician in a small town can place great hardship on individuals for miles around), Crowley devised techniques which not only precluded hospitalization, but took advantage of the need for the drug-abusing professionals to learn to work without drugs while exposed to them on a daily basis. He used the techniques of behavior modification therapy to assure compliance with a non-drug-using lifestyle. By establishing formal rules using the technique of contingency contracting, dramatic and abrupt reductions in drug use were achieved. Contingency contracting in this instance involves preparing an agreement between the therapist and the client which requires that in the event the client breaches this agreement, a prepared and signed letter from the client will automatically be mailed to his or her professional association or licensing agency, informing them of the clients drug-busing behavior. The patients remained in their usual environment, they continued to work, to provide the services that were

needed, while unlearning previous compulsive drug-using behaviors and learning new ways to interact with their colleagues, friends, and families. Dr. Crowley took advantage of all of the normal activities available in the environment to enhance the likelihood of success. These approaches deal with the real and everyday interactions which the former drug user must handle.

PSYCHOTHERAPEUTIC APPROACHES

Beyond the specific behavior modification approaches are those which take advantage of the more traditional psychotherapeutic strategies. Often the cocaine user may have a history of problems for which drug use had been a form of self-medication. Even when this is not the case, there may be an advantage in providing psychotherapy for those patients who might benefit by the experience.

As is often the case with chronic high frequency abusers of psychoactive drugs, cocaine abusers can demonstrate marked psychopathology. Whether that pathology caused, contributed to, or was caused or exacerbated by the substance abuse, it can become a focus of treatment. It is a rare chronic abuser who does not demonstrate social or psychological areas of impaired functioning even after the substance abuse behaviors have been discontinued. A diagnosis of the particular pathology of the individual must be accomplished and a treatment developed accordingly. For a few, usually more moderate abusers, shorter term more directive systems and/or cognitive oriented strategies of psychotherapeutic attention to the psychopathology and its attendant social and interpersonal disruptions may be sufficient for an effective intervention. For the large majority of abusers, specific attention must be given to confronting and overcoming the drug use behaviors themselves. This may be done using the behavior modification techniques already mentioned or, in many cases, through the types of psychotherapeutic strategies proven effective with alcoholics and other substance abusers.

PHARMACOTHERAPY

In addition to behavior modification therapy and psychotherapy, a study is being made of the utility of psychotherapeutic drugs with cocaine abuse patients.

As Kleber has noted, "despite past assumptions that cocaine abuse is a 'psychological addiction,' it is plausible that chronic cocaine abuse could lead to neurophysiological adaptations which require more than psychological intervention---(that is) the nervous system's usual response to persistent neurochemical agitation is compensatory adaptation"---and this is likely to occur with cocaine. This does not mean a classic abstinence syndrome and tolerance uniformly occur: rather chronic high dose use may generate sustained neurophysiological modification whose clinical manifestations are psychological. Kleber and his colleagues are evaluating the effects of various drugs which might greatly assist in treatment.

Indeed, the research in the laboratory and the clinic, devoted to the development of better treatment procedures provides, for inestimable opportunities for advances in the fields of pharmacology, psychiatry, psychology, and biobehavioral science. This in turn feeds back and permits unique opportunities for the development of new treatment techniques which will aid us in stemming the problems of cocaine abuse but also assist in treatment of related behavioral disorders. (Grabowski, April, 1985.)

While new treatment approaches continue to be developed, the basic elements of sound medical therapeutics continue to be applicable to effective treatment:

1. Early diagnosis and screening
2. Referral to appropriate treatment
3. Active support and involvement of family and significant others
4. Posttreatment support and aftercare.

For local treatment services information, you can contact your single State authority for drug abuse prevention (SSA) (see attached resource sheet) or for general information, you can contact the (800) COCAINE hotline .

The Maryland Drug Abuse Administration has published an abridged directory of cocaine treatment programs in the United States. For information about this publication, you should write to:

Howard Silverman, Director
Maryland State Drug Abuse Administration
201 West Preston Street
Baltimore, MD 21201
Telephone: (301) 383-3312

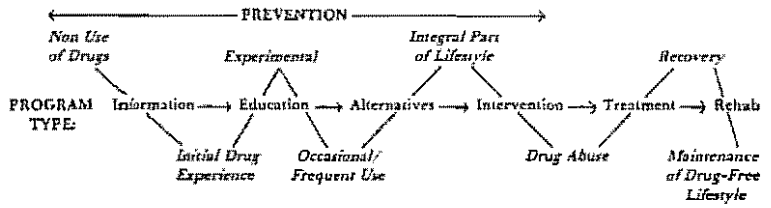
There may be other resources in your local community. Voluntary organizations such as Narcotics Anonymous and Cocaine Anonymous have chapters in many larger communities. These will usually be listed in the white pages of the telephone directory.

PREVENTION ISSUES

Prevention programming as briefly outlined in the introductory letter involves planned activities which logically fall along that continuum already mentioned but restated here.

NIDA places prevention, treatment, and rehabilitation activities along a Drug Abuse Program Continuum, as follows: *

Figure 1. NIDA Drug Abuse Program Continuum



Within this framework, specific programs or program types targeted at particular audiences can be identified. Typical of prevention programs are drug education in schools, recreational alternatives, peer counseling, employee wellness programs, community action projects, and information and referral centers. Treatment and rehabilitation programs include therapeutic communities, outpatient counseling, and methadone maintenance. It is important to stress that this continuum is not intended to restrict prevention activities to any one point. Instead, it indicates for each point the modality which is expected to have the major effect. This does not negate the potential influence of other modalities at a given point, since any modality can be expected to have at least some influence.*

The material presented in this package is intended to be informational and educational. Those looking for prevention models specific to cocaine are likely to be disappointed. To the best of our knowledge at NIDA, none have been developed or identified. Most experts believe that the foregoing prevention model will prove as useful for cocaine as it has for marijuana and other drugs.

For another perspective, Teresa Kunzman-Seppalo in A Primer on the Prevention of Chemical Use, Hazelden, Center City, Minnesota, 1977, states quite succinctly that:

> "prevention can be partially accomplished by enhancing one's social competencies - competencies which promote healthy personal functioning. The following have been cited as elements of social competencies that can be capitalized upon:

*Handbook for Prevention Evaluation, Prevention Evaluation Guidelines, NIDA 1981.

trust (reliance upon the affection of other people), self-confidence (confidence in one's capabilities and capacities to effect change in the environment), directionality (a sense of purpose and direction in life), identity (an integrated and coherent self-identity), perspective-taking (the ability to empathize with others), and interpersonal skills (those skills used to build and maintain productive and fulfilling relationships so that one is socially effective)".

Disseminating accurate information as a part of the educational process is seen as a legitimate way to enhance personal as well as community functioning.

Communities already engaged in prevention activities may wish to reexamine their needs assessment data and their initial prevention plan to see if there is a need to incorporate cocaine information/education activities in their efforts and then determine where in their plan of activities it would be most appropriate to insert this effort.

For communities which have yet to start any prevention program, we would stress the need first to determine the kind of drug problem you have and then develop an appropriate action plan. The Prevention Planning Workbook can assist you in this endeavor.

In addition to the resources described in this information package, the NIDA Prevention Branch can provide technical assistance should you develop a specific question on prevention programming. Remember also that in each Single State Authority for Drug Abuse there is a designated Prevention Coordinator who is a member of the National Prevention Network.

The Prevention Coordinator will be able to provide additional prevention information and is well versed on examples of prevention activities in your State. His/her name and address are included in the list of additional resources.

COCAINE RESOURCES SELECTED ANNOTATIONS

The following references, which also appear on the attached list, are described in more detail because they are more readily available and have been reviewed by Institute staff. They offer the reader an opportunity to read for greater detail and depth of understanding than is possible or intended in the preceding descriptive summary.

Opinions expressed in these resources are those of the authors and producers and do not necessarily reflect the opinions or official policy of the National Institute on Drug Abuse or any other part of the U.S. Department of Health and Human Services.

BOOKS AND PAMPHLETS

Cohen, Sidney M.D., Ph.D., Cocaine Today, American Council on Marijuana and other Psychoactive Drugs Inc., Rockville, Maryland 1981.

This little pamphlet provides a rich source for accurate information on the history of cocaine use. It describes the cultivation of the coca bush and the characteristics of the various forms of the coca alkaloids which are consumed by man. It reviews the psychopharmacology of the drug in animals and man and in some detail looks at modes of administration and the addicting potential of cocaine. Although it is a little dated, it is one of the better resources available for the general reader. It also includes a good list of additional reading.

Cohen, Sidney, M.D., Ph.D. Cocaine: The Bottom Line. American Council for Drug Education, Rockville, Maryland, 1985.

This booklet updates Cocaine Today. It includes current research on the addictive nature of cocaine, updates the description of use patterns, routes of administration, and describes the emerging problem of cocaine abuse in the supply countries. It also includes a self-administered set of questions on cocaine. It is intended to be a companion to Cocaine Today.

DuPont Robert L. Getting Tough on Gateway Drugs; A Guide for the Family. American Psychiatric Press, Inc., Washington, D.C., 1984

This book examines in detail three drugs which are frequently associated with drug abuse by youth: alcohol, marijuana, and cocaine. The physical and psychopharmacological aspects of the drugs are described along with the social and cultural contexts in which abuse of these substances occurs. The process of abuse is described for each and suggested points for prevention and early intervention are discussed.

This book is useful because it provides for the general reader a good survey of current information on drug abuse history, epidemiology, pharmacology, prevention, and treatment. A list of additional resources is presented.

Hafen, Brent Q, Ph.D., and Frandsen, Kathryn J. Cocaine. Hazelden Foundation, Center City, Minnesota, 1981.

This booklet specifically on cocaine covers much the same topic areas as Cocaine Today, but is perhaps a little more readable for the lay public. The reader is alerted to one caveat about this book. The first paragraph page 24 in the first paragraph it states: "It is hoped that through informing people about the consequences of substance use and abuse, educating them about responsible use of substances and through an indication of how to deal with behavioral problems, substance abuse will become less attractive".

Hazelden, in a telephone conversation, stated that the sentence part reading "responsible use of substances" refers to medical applications only in the case of cocaine and to other prescription drugs. In no way, do they support the "responsible use" of any illegal substance.

You will also note that Hazelden has produced a number of films on cocaine which are described on the attached resource list.

MAGAZINES, JOURNALS, AND NEWSPAPER ARTICLES

Hammer, Signe and Hazleton, Lesley "Cocaine and the Chemical Brain", Science Digest, pp. 58-61, 100, 101, 103, January, 1985.

This is a well written article reporting on current research. It describes tolerance, withdrawal, the cocaine reward, and some implications for treatment.

Maranto, Gina reported by Oemak, Richard "Coke: The Random Killer", Discover, March, 1985.

This article reviews some of the history of cocaine, some of the current research findings, describes the current use patterns and provides an excellent illustration of how cocaine is believed to work in the brain.

Swerthlow, Frank "Cocaine, Hollywoods Costliest Habit", Cosmopolitan, pp. 239-242 June, 1984.

This article chronicles the association of cocaine and the Hollywood Sun. Appears largely based on anecdotal reports.

Weitz, Alan "Cocaine, A Pretty Poison", Mademoiselle, pp. 7-9, March, 1985.

This article attacks the primary myth that cocaine is a glamorous, safe, and chic drug. It examines the addiction question, the cocaine and pregnancy question, and the general debilitation which accompanies chronic use.

FILMS

- COCAINE ABUSE: END OF THE LINE

  Richard Dreyfuss narrates a film about five people of different ages and walks of life who became addicted to cocaine. Dramatizations by the actual users show the progression of the addiction until they are led to seek help. Each has been through difficult cocaine rehabilitation which appears successful. Each feels a new positiveness about living life without cocaine. This film features treatment.

  27 minutes

  Audience: High School and Adult
  Produced by: Aims Media
  Distributed by: Aims Media, 6901 Woodley Avenue, Van Nuys, CA 91405-4878. (818) 785-4111.

- COCAINE: BEYOND THE LOOKING GLASS

  A poignant documentary of four rehabilitated cocaine users who reveal the steps they took that led them from first use to addiction and psychological dependency. All four sought help for their addiction and present a positive and hopeful picture of successful rehabilitation.

  30 minutes

  Audience: High School and Recovery Users
  Produced by: Dick Young for Hazelden Education Materials
  Distributed by: Hazelden Education Materials, Film Department, 15425 Pleasant Valley Road, Center City, MN 55012. 1-800-328-0500 (outside MN) or 612-257-4010 (inside MN).

- COCAINE BLUES

  A graphic honest portrayal of one of today's important social issues. Exploring cocaine's history, effects and cultural impact, it is the true story of drug abuse told by people from all walks of life. Narrated by Hoyt Axton, this remarkable film features: revealing encounters with users, narcotics officers and interviews with leading medical experts. Cocaine Blues won a Gold Award from the Houston International Film Festival.

  30 minutes

  Audience: High School and Adult
  Produced by: Barbour Langely and Associates
  Distributed by: Pyramid Films, Box 1048, Santa Monica, CA 90406. (213) 828-7577.

- COCAINE CARTEL

  An ABC News "close-up" documentary that traces the trail of illicit drug funds from banks in New York, Miami, and Panama to Bogota, Columbia where vast sums of illegal cash are laundered. The documentary examines how these sophisticated and highly organized criminals build their empires, how they violently maintain their trade and how they seriously disrupt the national and international economies.

  60 minutes

  Audience: Adult
  Produced by: ABC News
  Distributed by: Not available for distribution at this time. If interested in this videotape please contact: Ms. Sharon Rehme, ABC Wide World of Learning, 1330 Avenue of the Americas, New York, NY 10019.

- COCAINE PAIN

  The story of the intense struggle five people face as they try to conquer cocaine addiction which has ruined their lives. Viewers become emotional participants in painfully honest therapy sessions led by Dr. Richard L. Miller, Founder and Director of Cokenders. The epilogue reveals that four of the five people go back to cocaine use.

  32 minutes

  Audience: High School and Adult
  Produced by: Jay Gary Mitchell Film Company
  Distributed by: Simon & Schuster, 108 Wilmot Road, Deerfield, Illinois 60015. 1-800-621-7870.

- COCAINE - THE HIGHS AND LOWS

  Mark Gold
  Charlotte Hunter
  Conway Hunter

  Using an interview format, Charlotte Hunter, a former cocaine addict with a history of alcohol abuse retraces the steps that led to her addiction, treatment and recovery. Her personal journey is illumined by the professional insight of Conway Hunter M.D., and Mark S. Gold M.D., Panel Format.

  28 Minutes

  Audience: Adult
  Produced by: Touchstone Communications Associates
  Distributed by: FMS Productions, 1777 N. Vine Street, Los Angeles, CA 90028. 1-800-421-4509.

- SNOWSTORM IN THE JUNGLE

  Captain Jacques Cousteau and his son Jean Michele Cousteau, take a unique and unprecedented look at cocaine trafficking and production in the Amazon basin. During the 18 months exploration of the Amazon they encounter the manifestation of the cocaine problem from the ritual use of the coca leaf among the Indian culture to the harvest and trade for profit by the ruthless traffickers involved in export from Columbia and Peru.

  47 minutes

  Audience: High School and Adult
  Produced by: Cousteau Society and Turner Broadcasting
  Distributed by: Turner Broadcasting, 1050 Techwood Drive N.W, Atlanta, GA 30318. (404) 827-2200

- THE COCAINE TRAIL

  Cocaine -- America's new number one drug kick. Where does it come from? What measures are being taken to control it? An interesting and thorough examination of the "coke" problem. Shows how and where it is grown and manufactured and its many routes into the United States.

  25 minutes

  Audience: High School and Adult
  Produced by: NBC News
  Distributed by: Simon Schuter, 108 Wilmot Road, Deerfield, Illinois 60015. 1-800-621-7870

- THE PHYSIOLOGICAL EFFECTS OF COCAINE

  Cocaine use is increasing at a faster rate than any other drug. Now there is help for professionals who need comprehensive facts in understanding cocaine. Randy R. Cox, Ph.D., C.C.D.P., a licensed pharmacologist and chemical dependency counselor describes the physical properties of cocaine, its effect on bodily systems, and the common methods of street use. An excellent teaching tool for professionals.

  20 minutes

  Audience: Professionals
  Produced by: Hazelden Education Materials
  Distributed by: Hazelden Education Materials, Film Department, 15425 Pleasant Valley Road, Center City, MN 55012.
  1-800-328-0500 (outside MN) or (621)257-4010 (inside MN).

The following list cites additional resources. We have noted that in the last year or so more articles on cocaine are appearing in specially targeted magazines such as Science Digest, Discover, Cosmopolitan, etc. Many more articles are appearing in daily and weekly newspapers and journals. Keeping in touch with current events on cocaine doesn't appear terribly difficult. However, it is important to keep in mind that publications place differing emphases and present different focuses on the subject. Reading articles from several sources is likely to serve one better than reading only those articles on cocaine which appear in one or two selectively targeted magazines or journals.

COCAINE RESOURCE MATERIALS

BOOKS

[Books written prior to 1981 may not reflect some of the more recent and emerging research findings on cocaine treatment and prevention.]

Adler, Patricia A. Wheeling and Dealing. New York, NY: Columbia University Press, 1985.

Arnao, Giancarlo. Cocaine. Milano: Feltrinelli Economica, 1980.

Bartone, J.C. Medical Subject Research Index of International Bibliography Concerning Cocaine, American Research Institute Ltd., 1982.

Camacho, Gudizado, Alvaro. Droga, Corrupcion y Poder. Cali, Columbia: CIDSE, Universidad del Valle, 1981.

Centellas, G.; Maria, Jose. La Verdad Sobre la Coca y La Cocaina. La Paz: Institute Boliviano de Estudios de Comunicacion Social, 1981.

Cocaine, a Second Look. Rockville, MD: American Council on Marijuana and Other Psychoactive Drugs, 1983.

Cohen, Sidney. Cocaine Today. New York, NY: American Council on Marijuana and Other Psychoactive Drugs, 1981.

The Coke Book: The Complete Reference to the Users and Abuses of Cocaine Berkeley Publishers, 1984.

Dolan, Edward R. International Drug Traffic. New York, NY: Pt. Watts, 1985.

DuPont, Robert L. Getting Tough on Gateway Drugs: A Guide for The Family Washington, D.C.: American Psychiatric Press, 1984.

Englemann, Jeanne M. Cocaine: Beyond the Looking Glass Discussion Guide Center City, MN: Hazelden Publishers, 1984.

Fromme, Marlene, et al. Cocaine Seduction and Solution. New York: Crown Publishers, 1984.

Gold, Mark S. 800-Cocaine. New York: Bantam Books, 1984.

Hafen, Brent W; Frandsen, Kathryn J. Cocaine. Center City, MN: Hazelden Publishers, 1982.

Interamerican Seminar on Medical and Sociological Aspects of Coca and Cocaine. Cocaine 1980. Lima, Peru: Lima Pacific Press, 1980.

Kennedy, Joseph. Coca Exotica. New York, NY: Cornwall Books, 1984.

Learn About Cocaine. Center City, MN: Hazelden Publishers, 1983.

Medical Subject Research Index and International Bibliography Concerning Cocaine. Georgetown University, Washington, D.C.: ABBE Publishers, 1982.

Miller J; Cisin, I. Highlights from the National Survey on Drug Abuse: 1979. Superintendent of Documents, U.S. Government Printing Office, Pub. No. (ADM) 80-1032, 34 pp., Washington, D.C., 1980.

Mortimer, William G. Peru: History of Coca, "the Divine Plant" of the Incas. Reproduction of 1901 ed, New York: AMS Publishers.

Narcotics Intelligence Estimate: The Supply of Drugs to the U.S. Illicit Market from Foreign and Domestic Sources in 1983 (with projections through 1984). U.S. Drug Enforcement Agency, 54 p., Washington, D.C., 1984.

National Institute on Drug Abuse. Cocaine: Pharmacology, Effects, and Treatment of Drug Abuse. Research Monograph 50. Grabowski, John, ed. Washington, D.C., Supt. of Documents, U.S. Government Printing Office, 1984.

National Institute on Drug Abuse. Highlights from the National Survey on Drug Abuse: 1982. 39 pp., Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 1983.

National Institute on Drug Abuse National Survey on Drug Abuse: Main Findings 1982. Superintendent of Documents, 158 pp., U.S. Government Printing Office, Washington, D.C., 1983.

National Institute on Drug Abuse "Just Say No" Packet. 1983-1984 NIDA Media Campaign. National Clearinghouse for Drug Abuse Information, Kensington, MD (6 pamphlets), 1983.

National Institute on Drug Abuse Highlights from the National Survey on Drug Abuse: 1982. 39 pp., Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 1983.

Oversight on Illegal Drug Trafficking from Bolivia and U.S. Washington, D.C: Supt. of Documents, U.S. Government Printing Office, 1981.

Peterson, Robert C., et al. Cocaine: A Second Look. Smith David E; Dogoloff, Lee, eds. Rockville, MD: American Council on Drug Education, 1983.

Phillips Caballero, A. Gaston. Coca, Cocaina, Trafico. La Paz: Empresa El Diario, 1983.

Solution. 1st ed. New York, C.N. Potter, Distributed by Crown Publishers, 1984.

Spotts, James V. Cocaine Users. New York, NY: Free Press, 1980.

Spotts, James V.; Shontz, Franklin C. Cocaine Users: A Representative Case Approach. New York, NY: Free Press, 1980.

Stone, Nannette. Cocaine. New York, NY: C.N. Potter, Distributed by Crown Publishers, 1984.

Stone, Nannette; Fromme, Marlene; Kagan, Daniel. Cocaine: A Seduction and Solution. 1st ed. New York, NY: C.N. Potter, Distributed by Crown Publishers, 1984.]

Sutphen, Trenna. Final Cut: A Life Changing Self-Help Program to Quit Cocaine. Trenna Productions Publishers, (privately published) 1984.

Weiner, Michael. Getting Off Cocaine, Thirty Days to Freedom: The Step-by-Step Program of Nutrition and Exercise. New York, NY: Avon Books, 1984.

MAGAZINES, JOURNALS, PROCEEDINGS AND CONGRESSIONAL HEARINGS

"A Day on the Hotline." Ladies Home Journal, v. 101, p. 121, Mar. 1984.

"Alcohol and Other Drug Abuse Among Adolescents." Statistical Bulletin, pp. 4-13, Jan-Mar 1984.

Anderson, Jurt. "Crashing on Cocaine." Time, v. 121, Apr. 11, 1983.

Baber, Asa. "Behind Hollywood's Mirrors." Playboy, v. 30, Mar. 1983.

Beck, Melina. "Feeding America's Habit; a Booming Demand Frustrates Law-enforcement Efforts." Newsweek, v. 105, p. 22, Feb. 2, 1985.

Bower, Bruce. "Teen Drug Use - Except Cocaine - Falls." Science News, v. 127, p. 38, Jan 19, 1985.

Bush, Larry. "The Anatomy of Scandal: Who Created It? For What Purpose?" Advocate, No. 353, Oct. 14, 1982.

Chass, Murray. "Players' Union Challenges Suspensions." Sporting News, v. 197, p.43, Jan. 23, 1984.

"Cocaine: America's $50 Billion Snort." U.S. News and World Report, v. 97, p. 8(1), Dec. 10, 1984.

"Cocaine's Dangerous Rewards." Science News, v. 125, p. 238(1), April 14, 1984.

"Cocaine Smoking May Cause Lung Damage." Science News, v. 126, p. 37(2), July 21, 1984.

"Cocaine: The Evil Empire." Newsweek, v. 105, Feb. 25, 1985.

"Contaminated Cash in Miami." Time, v. 125, p. 22(1), Feb. 4, 1985.

"Corralling the Cocaine Cowboys on the Corporate Range." Boston Magazine, v. 77, pp.123-126, 150-153, Jan. 1985.

Demares, Michael. "Cocaine: Middle Class High". Time. p. 118, July 6, 1981.

Daly, Michael "Mother Courage: How a Plucky Woman Broke a $3.5 Billion Cocaine Ring". New York, v. 17, Nov. 12, 1984.

Ferrell, David "Cocaine Anonymous." Los Angeles Times, Part II: 1,2,3. Jan 3, 1984.

Flaherty, Tom. "Five Players Implicated in Cocaine Investigation." Sporting News, v. 197, p. 36 May 14, 1984.

"George Kirby Says God Put Him In Prison To Turn Him Around." Jet, v. 67, p. 14(2), Feb. 4, 1985.

"Getting Straight." Newsweek, v. 103, June 4, 1984.

Gold, Mark S.; Annitto, William J. "Do You Know the Facts About Drugs?" Fair Oaks Hospital, Summit, N.J. 47 pp., 1983.

Gomez, Linda. "Cocaine; America's 100 Years of Euphoria and Despair." Life, v. 7, p. 57, May 1984.

Greider, William. "Trial by Silhouette." Rolling Stone, No. 389, Feb. 17, 1983.

Halsey, Ashley III. "The Losing War Against Cocaine Smuggling." Philadelphia Inquirer, pp. 12-19, 24-25, 30-34. Apr. 24, 1983.

Hammer, Signe; Hazleton, Lesley. "Cocaine and the Chemical Brain: How the Drug May Alter the Action of Delicate Neurons." Science Digest, v. 92, p. 58, Oct. 1984.

"Harold Melvin Pleads Guilty To Drug." Jet, v. 66, p. 38(1), April 23, 1984.

Henderson, Thomas "Confessions of a Cocaine Cowboy." Playboy, v. 28, Dec. 1981.

House of Representatives, Select Committee on Narcotics Abuse and Control Control. A Major Drug Issue of the Seventies. Select Committee on Narcotics Abuse and Control, Washington, D.C. 142 pp., 1980, Hearings.

Huyghe, Patrick. "A Cure for Cocaine?" New York, v. 17, Oct. 22, 1984.

Jahnke, Art. "Cocaine Goes to the Head of the Class." Boston Magazine, v. 76, pp. 130, 132-133, 178-180, Sept. 1984.

Jeri, F.R. Ed., "Cocaina 2980: Actas del Seminario Interamericano Sobre Aspectos Medicosy Sociologicos de la Coca y de la Cocaina." Pacific Press, 307 pp., Lima, Peru, 1980.

Johnson, Robert E. "Celeb Vignette; Natalie Cole Says her Famous Father's Ghost Guides Her." Jet, v. 67, p. 16, Jan. 28, 1985.

Kandell, Jonathan "The Great Bolivian Cocaine Scam." Penthouse, v. 14, Sept. 1982.

Karlen, Neal. "Cocaine's Rock Houses." Newsweek, v. 105, p. 33, Feb. 11, 1985.

Kaye, Elizabeth. "One Woman's Triumph Over Cocaine." Glamour, v. 82, p. 248, Dec. 1984.

Karangianis, Maria. "Dial C-O-C-A-I-N-E." Boston Globe Magazine, July 10, 1983.

Kim, Sehwan. "Short-Term Effect of a National Prevention Model on Student Drug Abuse." Journal of Primary Prevention, v. 4, No. 2, pp. 118-128, Winter, 1983.

Kohn, Howard. "Cocaine, You Can Bank On It." Esquire, v. 100, Oct. 1983.

Latham, Aaron. "Anatomy of a Sting: John DeLorean Tells His Story." Rolling Stone, No. 391, March 17, 1983.

Lauren, Bill. "Cardial Snorts." Omni, v. 7, p. 36, Feb. 1985.

Leepson, Marc. "Cocaine: Drug of the Eighties." Congressional Quarterly, Washington, D.C., 1982.

McCarron, Margaret M. "The Cocaine 'Body Packer' Syndrome." Journal of the American Medical Association, v. 250, Sept. 6, 1983.

Maranto, Gina. "Coke: The Random Killer." Discover, March 1985.

Mirkin, Gabe. "Cocaine Con." Health, v. 17, p. 8, Jan 1985.

Mittleman, Wallace S.; Mittleman, Roger E.; Elser, Bernard. "Cocaine." American Journal of Nursing, v. 84, Sept. 1984.

Mittleman, Roger E.; Wetli, Charles V. "Death Caused by Recreational Cocaine Use: An Update." Journal of the American Medical Association, v. 252, Oct. 12, 1984.

Mothner, Ira; Weitz Alan. "How to Get Off Cocaine." Rolling Stone, p. 29, June 7, 1984.

O'Connell, Joan M.; Arnold, Bob. "Companies are Starting to Sniff Out Cocaine Users." Business Week, p. 37, Feb. 18, 1985.

Papazian, Ruth. "Cocaine: Breaking the Habit." Health, v. 16, p. 7, May 1984.

Phoenix House. "Cocaine." Phoenix House, 2 pp., New York.

Raab, Selwyn. "The New Addicts." New York Times, May 20, 1984.

Reese, Don; Underwood, John. "I'm Not Worth a Damn." Sports Illustrated, v. 56, June 14, 1982.

Rein, Richard K. "Cocaine Addicts Have A Friend At The End Of The Line: Counselor Mike Newman." People, v. 22, p. 101, Aug. 27, 1984.

Rooney, Rita. "Woman and Cocaine." Ladies Home Hournal, v. 101, p. 104, Mar. 1984.

Schultz, Carl B. "Statutory Classification of Cocaine as a Narcotic: An Illogical Anachronism." American Journal of Law and Medicine, v. 9, Summer, 1983.

Siegal, Ronald K. "Cocaine Fires." Omni, v. 7, p.36, Feb. 1985.

Silvan, Alice. "Cocaine Use and Employee Theft: A Workplace Issue." EAP Digest, December 1984.

"Sly Stone Is off Drugs: Coming Back With Help Of Friend Bobby Womack." Jet, v. 66, p12(3), July 2, 1984.

Smith, Dinitia. "My Husband was Hooked on Cocaine." Women's Day, p. 58, Feb. 5, 1985.

Special Issue on Cocaine. Bulletin on Narcotics, v. 36, Apr.-June 1984.

Spotts, James V.; Shontz, Franklin C. "Drug-Induced Ego States." International Journal of the Addictions, v. 19, April, 1984.

Tucker, Tim. "Braves' Pitching is Looking Shaky." Sporting News, v. 197, p. 41, Jan. 30, 1984.

Tyler, Joanna; Sheridan, John R. "Patterns of Primary Drug Abuse." International Journal of the Addictions, v. 15 (8) pp. 1169-1178, 1980.

Van Dyke, Craig; Byck, Robert. "Cocaine." Scientific American, v. 246, March, 1982.

Wang, Julia. "Cocaine & Sex: Thriller or Killer?" Harper's Bazaar, p.88, March 1984.

Watkins, Tom. "Fetal Cocaine Syndrome Appears a Possibility." Medical Tribune, (New York, NY), January 17, 1985.

Whelan, Edward P. "The White Plague." Cleveland Magazine, v. 12, Feb. 1983.

"Wilson Ready For May 15, Blue Will Stay In Shape. Jet, v. 66, p. 53(1), April 23, 1984.

Wisotsky, Steven. "Exposing the War on Cocaine: The Futility and Destructiveness of Prohibition." Wisconsin Law Review, v. 1983, No. 6, 1983.

RESOURCE FACT SHEET

For information about general drug and alcohol abuse programs, funding, and treatment services, contact your Single State Authority for drug and/or alcohol prevention at the following address:

Mr. John S. Gustafson
Assistant Director
Division of Substance Abuse Services
Executive Park South
Box 8200
Albany, New York 12203

For information about drug and alcohol abuse prevention programming in your State or region, contact your State Prevention Coordinator at the following address:

Mr. Neil Hook
Assistant Director for
Prevention Services
Executive Park South
Albany, New York 12203

For general literature on drug and alcohol abuse, contact respectively:

Drug Abuse

National Clearinghouse for Drug Abuse Information
(NCDAI)
P.O. Box 416
Kensington, MD 20795
(301) 443-6500

Alcohol Abuse

National Clearinghouse for Alcohol Information
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600

OPENING REMARKS
THE HONORABLE STAN PARRIS
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
"COCAINE ABUSE AND THE FEDERAL REPONSE"
JULY 16, 1985

THANK YOU MR. CHAIRMAN.

FOLLOWING THE PASSAGE OF THE HARRISON NARCOTIC ACT IN 1914 AND THE NARCOTIC DRUGS IMPORT AND EXPORT ACT OF 1922 WHICH HALTED THE WIDESPREAD USE OF COCAINE IN SOFT DRINKS, TONICS AND CERTAIN PATENT MEDICINES, GENERALLY SPEAKING, THE ORAL USE OF COCAINE DROPPED. INDEED, BETWEEN THE 1930'S AND THE LATE 60'S, COCAINE HAD NEARLY DISAPPEARED IN AMERICA.

IN THE EARLY 1970'S, THE FACT THAT THERE WERE VIRTUALLY NO CONFIRMED COCAINE OVERDOSE DEATHS AND ONLY A VERY SMALL NUMBER OF USERS SEEKING MEDICAL HELP OR SPECIALIZED TREATMENT LULLED THE AMERICAN PEOPLE AND, INDEED, DRUG EXPERTS INTO A FALSE SENSE OF SECURITY. COCAINE, AT THAT TIME, WAS CONSIDERED A "SAFE" DRUG AND ITS HIGH ABUSE POTENTIAL WAS NOT RECOGNIZED. THERE ARE MANY OTHER REASONS FOR THESE MISCONCEPTIONS, BUT IT IS NOT SO IMPORTANT TO GO INTO THAT TODAY. THE FACT IS, THEY WERE WRONG -- VERY WRONG.

A 1983 HOUSEHOLD SURVEY CONDUCTED BY THE NATIONAL INSTITUTES ON DRUG ABUSE SHOWED THAT THE NUMBER OF PEOPLE WHO HAD TRIED COCAINE AT LEAST ONCE HAD INCREASED FROM 5.4 MILLION IN 1974 TO 21.6 MILLION IN 1982. ANOTHER STUDY, THE BLANKEN STUDY, SHOWED THAT THE NUMBER OF CURRENT USERS OF COCAINE ROSE FROM 1.6 MILLION IN 1977 TO 4.2 MILLION IN 1982 -- A THREE-FOLD INCREASE IN ONLY FIVE YEARS. IT IS ALSO IMPORTANT TO NOTE THAT EMERGENCY ROOM ADMISSIONS ASSOCIATED WITH COCAINE USE ROSE BY THE SAME LEVEL DURING THAT SAME PERIOD OF TIME.

THE PRESENT EPIDEMIC OF COCAINE USE IS HORRIFYING AND YET, IT APPEARS AS THOUGH WE ARE ONLY SCRATCHING THE SURFACE. THE INCREASED PRODUCTION AND PROFITS WHICH ARE DERIVED FROM THIS EPIDEMIC OF USE HAVE RESULTED IN A MASSIVE DOMESTIC AND INTERNATIONAL ILLICIT COCAINE INDUSTRY WITH A VESTED INTEREST IN INCREASING, OR AT LEAST SUSTAINING, COCAINE USE.

THE DRUG ENFORCEMENT ADMINISTRATION, IN COOPERATION WITH THE STATE DEPARTMENT, IS HAVING TREMENDOUS SUCCESS IN WORKING WITH OTHER GOVERNMENTS TO HALT THIS AND OTHER DRUGS AT THE SOURCE.

INDEED, THE GOVERNMENTS OF BELIZE, MEXICO, BOLIVIA, COLUMBIA, PERU AND PAKISTAN, TO NAME A FEW, HAVE RADICALLY STEPPED UP EFFORTS TOWARDS ERADICATION OF ELLICIT CROPS SUCH AS OPIUM, POPPY, CANNABIS AND COCA. IN ADDITION, ITALY HAS ENACTED AN "ANTI-MAFIA" LAW WHICH ALLOWS THE GOVERNMENT TO SEIZE ILLEGAL DRUG PROFITS. MALAYSIA, HONG KONG, SINGAPORE AND THAILAND ARE WOKING TOWARDS SIMILAR LEGISLATIVE GOALS.

AS A PART OF THE PRESIDENT'S NATIONAL STRATEGY ON THE PREVENTION OF DRUG ABUSE AND DRUG TRAFFICKING, NUMEROUS MAJOR INITIATIVES HAVE BEEN UNDERTAKEN IN AN EFFORT TO DESTROY DOMESTIC AND INTERNATIONAL DRUG TRAFFICKING NETWORKS. CURRENTLY, FOURTEEN FEDERAL AGENCIES AND THE INTELLIGENCE AGENCIES ARE INVOLVED IN THE DRUG LAW ENFORCEMENT NETWORK. THIS ADMINISTRATION HAS COME DOWN HARD ON ORGANIZED CRIME AND DRUG SMUGGLING WITH THE ULTIMATE GOAL BEING THE COMPLETE ERADICATION OF BOTH.

PERHAPS THE MOST EFFECTIVE WEAPON AGAINST DRUG ABUSE IS A GOOD DRUG ABUSE PREVENTION PROGRAM FOCUSING ON THE EDUCATION OF OUR YOUNG PEOPLE. THIS IS ONE AREA WHERE, THROUGH DIRECT CONTACT, THE GREATEST IMPACT ON THE USER OR POTENTIAL USER CAN BE EFFECTED BY PARENTS AND PARENT GROUPS, STUDENTS, SCHOOL OFFICIALS AND HEALTH PROFESSIONALS.

IT IS GROUPS SUCH AS THESE THAT CAN PROVIDE THE STRONG MORAL FOUNDATION -- THROUGH EDUCATION AND VIGILANCE -- TO CHILDREN TODAY THAT WILL ENABLE THEM IN THE FUTURE TO MAKE THE INFORMED DECISION NOT TO ABUSE DRUGS OR ALCOHOL, BASED ON THE FACT THAT IT IS NOT AN ACCEPTABLE FORM OF BEHAVIOR IN THIS SOCIETY. IT IS UP TO US TO CREATE AN ENVIRONMENT IN WHICH DRUG ABUSE IS RECOGNIZED AS UNACCEPTABLE BEHAVIOR.

THANK YOU.

OPENING STATEMENT OF THE

HONORABLE JAMES H. SCHEUER, M.C.

BEFORE THE HOUSE SELECT COMMITTEE

ON NARCOTICS ABUSE AND CONTROL

"COCAINE ABUSE AND THE FEDERAL RESPONSE"

JULY 16, 1985

THERE CAN BE LITTLE DOUBT THAT COCAINE ABUSE IS GROWING AT AN ALARMING RATE AT ALL LEVELS OF OUR SOCIETY AND THAT IT IS A HEALTH PROBLEM OF INCREASING SEVERITY.

WHILE IT WAS ONCE THOUGHT TO BE A DRUG AVAILABLE ONLY TO THE VERY WEALTHIEST AMERICANS, IT IS CLEAR THAT COCAINE IN REACHING AN INCREASING NUMBER OF CITIZENS THROUGHOUT OUR SOCIETY.

IT HAS BEEN ESTIMATED THAT 8 TO 20 MILLION PEOPLE ARE NOW USING COCAINE -- FIVE MILLION ARE REGULAR USERS -- AND THAT AN ESTIMATED 5000 PEOPLE WILL TRY COCAIN FOR THE FIRST TIME EVERY DAY.

THE WORLD-WIDE GLUT OF COCAINE HAS BROUGHT THE PRICE OF THIS INSIDIOUS AND SEDUCTIVE DRUG DOWN TO WHERE IT IS POSSIBLE TO PURCHASE A GRAM FOR LESS MONEY THAN A GRAM OF MARIJUANA.

WITHOUT QUESTION, PART OF THE ANSWER IS INCREASED LAW ENFORCEMENT AND INTERDICTION EFFORTS.

BUT ATTACKING THE SUPPLY SIDE OF THE PROBLEM IS ONLY PART OF THE EQUATION.

WE MUST ALSO ATTACK THE DEMAND SIDE OF THE PROBLEM THROUGH DRUG ABUSE PREVENTION, TREATMENT AND REHABILITATION SERVICES.

TODAY'S HEARING IS AN IMPORTANT STEP IN APPROACHING THE DEMAND SIDE OF THE PROBLEM.

I COMMEND OUR FIRST PANEL OF WITNESSES FOR THEIR WILLINGNESS TO APPEAR BEFORE US TODAY AND TO SHARE WITH US THEIR UNIQUE INSIGHTS INTO THE PROBLEM OF DRUG ABUSE GENERALLY AND COCAINE ABUSE SPECIFICALLY.

I LOOK FORWARD TO THEIR TESTIMONY AND TO THEIR SUGGESTIONS AS TO WHAT WE CAN DO FROM A PUBLIC POLICY PERSPECTIVE TO CURB THE ABUSE OF COCAINE AND OTHER DRUGS.

WHILE THERE MAY ONCE HAVE BEEN A PERCEPTION THAT COCAINE WAS A "SAFE" DRUG, IT IS CLEAR THAT THIS IS NOT THE CASE.

JUST LAST WEEK, THE AMERICAN MEDICAL ASSOCIATION JOURNAL REPORTED THAT RECENT STUDIES ON LABORATORY RATS PRODUCED A 90% MORTALITY RATE IN ANIMALS GIVEN COCAINE FOR ONE MONTH, COMPARED WITH A 36% DEATH RATE AMONG THOSE GIVEN HEROIN.

ALONG WITH THE INCREASE IN THE AVAILABILITY AND ABUSE OF COCAINE, DEATHS ATTRIBUTED TO COCAINE HAVE ALSO SHOWN A DRAMATIC INCREASE.

IN 1979 AND 1980, THERE WERE 129 COCAINE-RELATED DEATHS REPORTED IN THE UNITED STATES.

IN 1983-84, THERE WERE 456 DEATHS ATTRIBUTED TO COCAINE.

HOW DO WE RESPOND TO WHAT IS OBVIOUSLY A GROWING EPIDEMIC?

The following article is included with the author's permission. Karst Besteman is the Executive Director of the Alcohol and Drug Problems Association of North America, Inc. (ADPA). His article first appeared in The Professional, the ADPA monthly newsletter, August 1985 issue.

Cocaine 'epidemic' response: Heroin revisited

By Karst Besteman

1985 HAS BEEN THE YEAR of raised awareness of the nature and danger of cocaine abuse and addiction. As events have occurred, there has been a sense of history repeating itself. For those of us who have been in the field 20 years or more, the similarities to the events of the late 60's, during the heroin crisis, are remarkable. Heroin was the most feared drug of abuse during the 60's. The entire governmental structure, the mass media, and public concern was focused on "the heroin problem."

In Congress, Senator Harold Hughes and Congressman Paul Rogers were convening hearings to examine the facts, and proposing legislation to respond. The hearings were producing new headlines indicating that heroin was spreading. Heroin addiction was leaving the ghetto, where it had been contained since World War II. The purity of the drug was increasing, as was the supply. The price of heroin was dropping. Heroin addiction, with its escalating overdose deaths, was leaving the big cities of the east coast and spreading across the Mid-West. Heroin addicts were no longer confined to minorities, petty criminals and character disorders. Heroin was contaminating our troops in Viet Nam. Loyal, patriotic young men were returning to this country scarred for life with drug addiction.

The media used the hearings to review in-depth the opium production in exotic lands. Routes of smuggling and clandestine laboratories were sketched and photographed. Methods of passing through customs were detailed, and paraphernalia and explicit accounts of "cooking" and "shooting" were often described and pictured. Precociously-addicted children became "star" witnesses in hearings and on the early evening news. Newspapers assigned a specific reporter to become "knowledgeable" and a drug beat was an opportunity for fast by-lines.

Public opinion was clear. Heroin addiction was a threat to the community. Addicts were forced to commit crimes to support their habits and, because of drugs, crime rates were skyrocketing. The streets of the city were no longer safe. Action must be taken! Public opinion was also firm on another issue. Do not open a treatment center in my neighborhood!

The executive branch of government was slow to act. The Johnson Administration had initiated a very limited response using the Office of Economic Opportunity, and was prepared to implement the Narcotic Addict Rehabilitation Act of 1966 by the summer of 1967. All other proposals being considered were resisted. In 1968, a new Nixon Administration came into office. This change involved a re-examination of the past, and a flurry of studies and reviews. During 1969 and 1970, the Administration opposed every legislative initiative of Congress. The President, in making a 10-point statement about the heroin problem, had nine items of interdiction and enforcement, and one stating addicts should be treated.

The State Department began to look at our friends and allies who were producing opium in excess, functioning as transhipment stations, heroin processing centers, and harboring international criminal elements. There was public speculation that "Red China" was encouraging opium production and smuggling from the Golden Triangle to undermine the integrity and effectiveness of our troops. There was fear of a Communist conspiracy.

The States of California and New York, as well as New York City, moved ahead of the federal response and initiated major heroin treatment programs. California's was clearly within the criminal justice system. New York chose to establish an independent Narcotics Control Commission. The New York City program introduced the use of ex-addicts in a publicly-funded program.

The professional community concerned with heroin addiction was small. The majority had been introduced to heroin addiction by assignment to the Public Health Service Hospital in Lexington, Kentucky. An additional group had experience from early programs in New York and California. The majority were salaried in the public sector. Because of the limited size and the public support of their professional activities, there was a great desire to share information and learn from one another. There were conferences which had as their main function sharing therapeutic efforts, successes and failures, and working out acceptable evaluative criteria and processes.

The private professional community was very small and for the most part, dedicated to the therapeutic community concept. The participants among this group were committed and very zealous. Their major philosophical commitment was the heavy involvement of the ex-addict in confrontational therapies, and their unwavering dedication to a "drug-free" status. The private program also shared information, techniques and strategies. All were overwhelmed by the demand for their services. It was a tense, challenging and exciting time.

This year in Congress, Senator Paula Hawkins (R-FL) and Congressman Charles Rangel (D-NY) are convening hearings to examine the facts and proposing legislative solutions. The hearings are designed to produce headlines that cocaine abuse is spreading and dangerous. Cocaine, long-associated with the super-wealthy and "jet-set," is infiltrating the world of the "young, upwardly-mobile professional." More alarming is the rapid decline of price, which enables blue-collar workers to use, and students to pool their movie or record money to purchase cocaine.

Suddenly, the media has discovered the old animal studies, easily replicated, which deliver the message of death by drug overdose, and complications of drug use and abuse. Again, the media is educating the public regarding the cultivation of the coca leaf in South America. Even the great Jacques Cousteau participates with a Turner Broadcasting System special. Articles about carriers swallowing bags of cocaine and dying from overdoses are interspersed with record seizures and accounts of the destruction of processing sites. *Newsweek*, *Time* and *Fortune* all feature cover articles. TV talk shows, news reports and public service discussion programs spend time on cocaine abuse. The morning "funnies" with Dr. Rex Morgan recount the gradual destruction of a successful businesswoman due to cocaine addiction. The explosion of cocaine-related deaths and emergency room visits are highlighted in featured articles.

Public opinion is only partially mobilized. Cocaine addiction is not associated with a clearly perceived danger. Parts of the country had an eruption of violence associated with major cocaine traffic. Personal danger and street crime have not been connected to the cocaine abuser. Most of the cocaine addicts are seeking treatment in private facilities, and display some third-party resources. The community is willing for the addict to pay for his own "stupidity."

The executive branch of government, having successfully instituted the block grant, has its chief drug advisor stating that if cocaine addicts can sacrifice their cars, homes, marriages and careers for the drug, they can certainly pay for their treatment. The White House has mobilized an inter-agency task force aimed mainly at interdiction, headed by the Vice President. Through the Public Health Service testimony, the Administration tries to impress congressional committees that although cocaine is the most reinforcing drug, and is much cheaper and more available, the pool of users is stable. The expanding number of casualties is merely the function of heavier use by persons already using the drug. No specific response is recommended.

The State Department is working with South American supplier nations to encourage greater local commitment to enforcement, plant eradication, and crop substitution. The results are inadequate. Greater acreage is planted, more sophisticated processing centers are devised, and greater supplies of the drug arrive in this country. Congress re-defines the legal restraints for use of the military for domestic programs. Again, the concern arose for governments who do not effectively control their entire country. The ties of drug trade and weapons shipment leads to the charge of "narco-terrorism" aimed at the stability and integrity of the United States.

The individual states start to respond. Statewide cocaine treatment centers are established. Certificates of need for private cocaine treatment centers receive rapid approval. The state agencies, in concert with private programs, are sponsoring meetings with cocaine as the sole subject. Teaching hospitals affiliated with university centers are opening modest treatment wards. These efforts are not well coordinated or planned as part of an over-arching strategy.

There are, in my opinion, two major differences in the response to the cocaine epidemic from the heroin crisis of the late 60's. First, there is no attempt to fashion a consistent response by federal, state and local collaboration. Second, within the professional community, there is not a sense of shared purpose. Both of these differences impede our success.

The pattern of response to heroin was led by a federal effort to strengthen and enhance the states' efforts to respond. This effort went well beyond the funding mechanism which is now handled in the block grant. The federal effort included training in clinical skills of persons new to the field, setting clinical treatment standards to share lessons learned by others and responding to requests for technical assistance to solve management problems generated by these new programs. There was a constant pattern of communication facilitated and fostered by a participating federal program.

The second major difference has to do with actions within the professional community. Professionals were eager to share, impatient with their own failures, and open to suggestions. While there were some strong philosophical differences, all were most concerned with developing effective treatment programs, and presenting acceptable outcome data. Clinicians gave freely of their time to instruct colleagues and neophytes. Knowledge and progress concerns was assumed to be in the public domain. Today, things are quite different.

Programs and professionals today are "franchised." We advertise our availability to help on all the media. Proprietary interests and expansion plans keep us competitive and claiming positive success rates. We encourage all to come, and rarely refer to another program, because of the patient's unique situation. Our conversations are punctuated with market forces and investment return. We share little in way of the clinical reality that occurs in our program. The result is that we have fewer training and learning opportunities to enhance our clinical skills.

Isn't it time for us to declare the cocaine epidemic a national emergency, and for the professional community to unite in a concerted effort to meet the responsibility of expanding the availability of qualified effective clinical resources?